

Indian Children on a Psychiatrist's Playground

(Observations on Indian Children examined and treated at
Nur Manzil Psychiatric Centre, Lucknow, 1956-61)

by

ERNA M. HOCH

Dr. med., Specialist for Psychiatry FMH (Switzerland)



INDIAN COUNCIL OF MEDICAL RESEARCH

MEDICAL ENCLAVE (ANSARI NAGAR)

NEW DELHI

1967

PRICE : Rs. 12.25

Printed by Shri H. R. Sardana at the Cambridge Printing Works, Delhi-6.

Contents

	PAGE
I. Introduction	1
II. Characteristics of the Total Group of Children	10
1. Distribution according to Sex	10
2. Distribution according to Age	11
3. Reasons for Consultation	15
4. Diagnostic Categories	17
5. Local Origin	22
6. Community and Caste	25
7. Occupation of Father or Guardian	28
8. Joint and Individual Family	29
9. Lack of Parents	30
10. Heredity	32
11. Number of Siblings and Position in Sibling Row	37
12. Age of the Mother at the Child's Birth	44
13. Complications of Pregnancy and Delivery	47
14. The Period of Breastfeeding	48
15. Toilet Training	53
16. Early Neglect and Separation	54
17. Parental Attitudes	55
18. Physical Defects in the Children Examined	63
19. Former Illnesses	67
20. Education	69
21. Problems of Adolescence	69
22. Children's Interests	70
23. Methods of Examination	70
24. Possibilities of Treatment	76
III. The Individual Diagnostic Groups	82
1. <i>Synopsis</i>	82
2. <i>Oligophrenia</i>	82
(a) Definition and Differential Diagnosis	82
(b) Causes and Origin	87
(c) Combinations with other Psychiatric Disorders	96
(d) Characteristic Features in our Material	101
(1) Distribution according to Sex	101
(2) Distribution according to Age	101
(3) Reasons for Consultation	103

	PAGE
(4) Local Origin	... 103
(5) Community and Caste	... 104
(6) Occupation of Father or Guardian	... 105
(7) Joint Family	... 105
(8) Lack of Parents	... 106
(9) Heredity	... 107
(10) Number of Siblings and Special Position in Sibling-Row	... 110
(11) Age of the Mother at Child's Birth	... 112
(12) Complications of Pregnancy and Delivery	... 112
(13) The Period of Breastfeeding	... 113
(14) Toilet Training	... 114
(15) Early Neglect and Separation	... 114
(16) Parental Attitudes	... 115
(17) Physical Defects	... 119
(18) Former Illnesses	... 119
(19) Education	... 120
(20) Problems of Adolescence	... 122
(21) Children's Interests	... 123
(22) Number of Visits and Possibilities of Treatment	... 125
3. <i>Postencephalitic States</i>	... 125
(a) Definition, Differential Diagnosis	... 125
(b) Causes and Origin	... 128
(c) Combinations	... 132
(d) Characteristic Features in our Material	... 133
(1) Distribution according to Sex	... 133
(2) Distribution according to Age	... 133
(3) Reasons for Consultation and Main Symptoms	... 133
(4) Local Origin	... 134
(5) Community and Caste	... 134
(6) Occupation of Father or Guardian	... 135
(7) Joint and Individual Family	... 135
(8) Lack of Parents	... 135
(9) Heredity	... 136
(10) Number of Siblings and Special Positions in Sibling-Row	... 138
(11) Age of the Mother at Child's Birth	... 140
(12) Complications of Pregnancy and Delivery	... 140
(13) The Period of Breastfeeding	... 140
(14) Toilet Training	... 140
(15) Early Neglect and Separation	... 141
(16) Parental Attitudes	... 141
(17) Physical Defects	... 141
(18) Former Illnesses	... 142

	PAGE
(19) Education	... 144
(20) Problems of Adolescence	... 144
(21) Children's Interests	... 145
(22) Number of Visits and Possibilities of Treatment	... 146
4. <i>Epilepsy</i>	... 147
(a) Definition, Differential Diagnosis	... 147
(b) Causes and Origin	... 152
(c) Combinations	... 153
(d) Special Characteristics of our Material	... 154
(1) Distribution according to Sex	... 154
(2) Distribution according to Age	... 154
(3) Reasons for Consultation and Main Symptoms	... 158
(4) Local Origin	... 161
(5) Community and Caste	... 161
(6) Occupation of Father or Guardian	... 162
(7) Joint and Individual Family	... 162
(8) Lack of Parents	... 162
(9) Heredity	... 162
(10) Number of Siblings and Position in Sibling-Row	... 165
(11) Age of the Mother at Child's Birth	... 166
(12) Complications of Pregnancy and Delivery	... 166
(13) The Period of Breastfeeding	... 166
(14) Toilet Training	... 167
(15) Early Neglect and Separation	... 167
(16) Parental Attitudes	... 167
(17) Physical Defects	... 168
(18) Former Illnesses	... 169
(19) Education	... 169
(20) Problems of Adolescence	... 170
(21) Children's Interests	... 172
(22) Number of Visits and Possibilities of Treatment	... 173
5. <i>Other Organic Cases</i>	... 174
6. <i>Neurosis</i>	... 177
(a) Definition, Differential Diagnosis	... 177
(b) Causes and Origin	... 185
(c) Combinations	... 189
(d) Special Characteristics of our Material	... 191
(1) Distribution according to Sex	... 191
(2) Distribution according to Age	... 192
(3) Reasons for Consultation and Main Symptoms	... 195
(4) Local Origin	... 218

	PAGE
(5) Community and Caste	... 220
(6) Occupation of Father or Guardian	... 225
(7) Joint and Individual Family	... 226
(8) Lack of Parents	... 228
(9) Heredity	... 236
(10) Number of Siblings and Position in Sibling-Row	... 242
(11) Age of the Mother at Child's Birth	... 250
(12) Complications of Pregnancy and Delivery	... 252
(13) The Period of Breastfeeding	... 252
(14) Toilet Training	... 255
(15) Early Neglect and Separation	... 258
(16) Parental Attitudes	... 263
(17) Physical Defects	... 280
(18) Former Illnesses	... 283
(19) Education	... 285
(20) Problems of Adolescence	... 289
(21) Children's Interests	... 299
(22) Number of Visits and Possibilities of Treatment	... 300
(23) Conclusion	... 302
7. <i>Psychophysical Infantilism</i>	... 302
(a) Definition, Differential Diagnosis	... 302
(b) Causes and Origin	... 308
(c) Combinations	... 309
(d) Characteristics of our Material	... 310
8. <i>Infantile Psychosis</i>	... 320
(a) Definition, Differential Diagnosis	... 320
(b) Causes and Origin	... 329
(c) Combinations	... 332
(d) Characteristics of our Material	... 333
(1) Distribution according to Sex	... 333
(2) Distribution according to Age	... 334
(3) Reasons for Consultation and Main Symptoms	... 334
(4) Local Origin	... 339
(5) Community and Caste	... 344
(6) Occupation of Father or Guardian	... 346
(7) Joint and Individual Family	... 346
(8) Lack of Parents	... 347
(9) Heredity	... 357
(10) Number of Siblings and Position in Sibling-Row	... 364
(11) Age of the Mother at Child's Birth	... 369
(12) Complications of Pregnancy and Delivery	... 372

	PAGE
(13) The Period of Breastfeeding	... 373
(14) Toilet Training	... 378
(15) Early Neglect and Separation	... 379
(16) Parental Attitudes	... 380
(17) Physical Defects	... 381
(18) Former Illnesses	... 381
(19) Education	... 382
(20) Children's Interests	... 383
(21) Number of Visits and Possibilities of Treatment	... 383
9. <i>Adolescent Psychosis</i>	... 384
(a) Definition, Differential Diagnosis	... 384
(b) Causes and Origin	... 387
(c) Combinations	... 390
(d) Characteristics of our Material	... 393
(1) Distribution according to Sex	... 393
(2) Distribution according to Age	... 393
(3) Reasons for Consultation and Main Symptoms	... 395
(4) Local Origin	... 397
(5) Community and Caste	... 397
(6) Occupation of Father or Guardian	... 398
(7) Joint and Individual Family	... 399
(8) Lack of Parents	... 403
(9) Heredity	... 405
(10) Number of Siblings and Position in Sibling-Row	... 411
(11) Age of the Mother at Child's Birth	... 418
(12) Complications of Pregnancy and Delivery	... 418
(13) The Period of Breastfeeding	... 418
(14) Toilet Training	... 419
(15) Early Neglect and Separation	... 419
(16) Parental Attitudes	... 420
(17) Physical Defects	... 422
(18) Former Illnesses	... 425
(19) Education	... 425
(20) Problems of Adolescence	... 426
(21) Children's Interests	... 432
(22) Number of Visits and Possibilities of Treatment	... 433
IV. <i>Juvenile Delinquency</i>	... 435
1. <i>General Remarks</i>	... 435

	PAGE
2. <i>Characteristics of our Material</i>	... 438
(a) Distribution according to Sex and Age	... 438
(b) Education	... 439
(c) Local Origin	... 440
(d) Community and Caste	... 440
(e) Occupation of Father or Guardian	... 441
(f) Lack of Parents	... 442
(g) Position in the Sibling-Row	... 442
(h) Parental Attitudes	... 442
(i) Diagnostic Categories	... 444
(j) The Delinquent Features	... 445
3. <i>Individual Case Histories</i>	... 447
(a) Delinquent Group	... 448
(1) Mental Deficiency	... 448
(2) Postencephalitic State	... 452
(3) Neurosis	... 453
(b) Potential Delinquents	... 463
V. Conclusion	... 468
Index of Case Histories Quoted	... 479
Index of Reference	... 483
Glossary of Hindi Terms	... 485

INDEX OF TABLES

A. **Tables Referring to the Total Group** (*Annexed separately in a booklet at the end of the book*)

I. Sources of Referral	... 2
II. Number of Consultations	... 4
III. Local Origin and Migration	... 6
IV. Reasons for Consultation and Main Symptoms	... 8
V. The Diagnostic Groups and their Combinations	... 10
VI. Lack of Parents	... 12
VII. Heredity (incidence of psychiatric morbidity amongst relatives)	... 14
VIII. Parental Heredity (psychiatric morbidity in parents)	... 16
IX. Early mortality amongst the siblings	... 16
X. Position in the Sibling-Row	... 18

	PAGE
XI. Possible and Actual Special Positions in Sibling-Row and Excess Rates	... 20
XII. Age of the Mother at the Child's Birth	... 22
XIII. Complications of Pregnancy and Delivery	... 24
XIV. Period of Breastfeeding	... 26
XV. Parental Attitudes (summed up for congenital-organic, combined and functional groups)	... 28
XVI. Physical Defects in Children Examined	... 30
XVII. Former Illnesses	... 32
XVIII. Synopsis of Characteristic Features Congenital—organic groups	... 34
XVIII A. Synopsis of Characteristic Features Functional Groups	... 38
B. Tables Referring to Individual Diagnostic Categories. (<i>In the text</i>).	
1. Distribution of Oligophrenic Children amongst the 3 grades of Deficiency	... 84
2. Combination of Oligophrenia with other Psychiatric Disorders	... 96
3. Distribution of Oligophrenics according to Age	... 102
4. Distribution of Hindu Castes amongst Grades of Mental Deficiency	... 104
5. Heredity according to Grades of Mental Deficiency	... 108
6. Educational Standard of Oligophrenic Children	... 120
7. Interests of Oligophrenic Children	... 124
8. Former Illnesses of Post-encephalitic Children	... 142
9. Educational Standard of Post-encephalitic Children	... 144
10. Interests of Post-encephalitic Children	... 145
11. Combination of Epileptic Manifestations with other Psychiatric Disorders	... 153
12. Onset of symptoms in Epileptic Children	... 155
13. Educational Standard of Epileptic Children	... 169
14. Interests of Epileptic Children	... 172
15. Combinations of Neurosis with Disorders of Congenital and Organic Type	... 190
16. Duration of Symptoms before First Consultation (Neurotic Group)	... 193
17. Distribution of Neurotic Symptoms according to Community	... 221
18. Duration of Neurotic Symptoms before First Consultation according to Community	... 222
19. Educational Standard of Neurotic Children	... 285
20. Interests of Neurotic Children	... 299
21. Synopsis of Relevant Factors in Psychotic Children	... 330
22. Main Features in Psychotic Children arranged according to Predominance of Organic-Constitutional and Psychogenic Factors	... 330
23. Onset of Symptoms in Psychotic Adolescents	... 394

	PAGE
24. Duration of Symptoms before First Consultation in Psychotic Adolescents	... 394
25. Main Symptoms in Psychotic Adolescents	... 395
26. Educational Standard of Psychotic Adolescents	... 425
27. Distribution of Children with Delinquent Features according to Age	... 439
28. Educational Standard of Children with Delinquent Features	... 440
29. Distribution according to Community and Caste of Children with Delinquent Features	... 441
30. Distribution according to Occupation of Father or Guardian of Children with Delinquent Features	... 441
31. Parental Attitudes in children with Delinquent Features	... 443
32. Distribution according to Diagnostic Categories of Children with Delinquent Features	... 444
33. The Delinquent Features	... 446

INDEX OF GRAPHS

A. Graphs Referring to the Total Groups (*Annexed separately in a booklet at the end of the book*)

I. Distribution according to Age : Total	... 42
(Ia) Distribution according to Age ; summed up into groups : (1—6, 6—11, 11—16).	... 43
(Ib) Distribution according to Age : Diagnostic Categories	... 44
II. Distribution according to Community	... 45
III. Distribution according to Hindu Caste	... 46
IV. Occupation of Father or Guardian	... 47
V. Joint and Individual Family	... 48
VI. Number of Siblings	... 49
VII & VIIa. Parental Attitudes	... 50
VIII. Number of Consultations (Main groups)	... 52
VIIIa. Number of Consultations (Diagnostic Categories)	... 53
IX. Result of Treatment (Main groups)	... 52
IXa. Result of Treatment (Diagnostic Categories)	... 53

B. Graphs Referring to Individual Diagnostic Categories (*in the text*) :

1. Onset of Symptoms in Neurotic Children	... 192
2. Main and Accessory Symptoms in Neurosis	... 193
3. Neurotic Symptoms in Joint and Individual Family	... 226
4. Neurotic Symptoms in Eldest Sons and Daughters	... 227
5. Neurotic Symptoms and Parental Attitudes	... 263

Foreword

IT IS INDEED a privilege for me to write this foreword in appreciation of Dr. Erna M. Hoch's book on "*Indian Children on a Psychiatrist's Playground*"—a book the like of which has not been published so far in India. The book, as the sub-title shows, is based on observations of Indian children examined and treated at Nur Manzil Psychiatric Centre, Lucknow, from 1956-61.

It is a unique book in many ways. In the first instance, its title is at once striking, thought-provoking and appealing. It reveals the author's creative attitude toward her patients—the attitude that is the cornerstore of all good and effective psycho-therapy. In the words of the author herself "it refers to the sphere of freedom and permissiveness, which the psychotherapist keeps open for his patients, so that, in its light and shelter, they may discover their potentials and try out their possibilities." Truly, the title highlights a progressive aspect of the functions of a successful psychiatrist in a growing democracy, the one who is very much alive to the rapid social and cultural change that is taking place in the country on account of such forces as technology, industrialisation and urbanisation, and who is not rigidly bound by any inflexible theory or a group of 'systems', alien or otherwise, but who, at the same time, does not forget to synthesise the contributions of such great masters in the field, as Freud, Adler, Jung, Boss, Bleuler, Tramer and Kanner.

The book is unique inasmuch as it is based on 216 case histories of children up to the age of 16, representing the various diagnostic groups. No doubt, the number of patients serving as the source material is small, yet, none can deny that it is a pilot study of its type. The smallness of the 'sample' has been compensated for by the depth and extensiveness of analysis of the clinical material gathered. In doing so, the author has added to the dimensions of the clinical insight which every practitioner, a psychiatrist or a clinical psychologist, would love or hopes to achieve. The vast array of variables on the basis of which each diagnostic group is analysed is characterised by comprehensiveness and integration : the approach is both horizontal and vertical. Perhaps, Dr. Hoch could achieve this laudable objective because she has presented the material in the pursuit of the literal "re-search" of experience gained in the process of rendering practical help; and I firmly believe, that the experience formulated and presented in such a meaningful way, is far more fruitful for a practising clinician than a vast plethora of theoretical constructs even though supported by the scientifically processed figures conforming to the rigours of statistics. This does not imply, nor do I mean to, that the author is "allergic" to statistical mathematics. She, as far as I can see, means to be more clinical than statistical in her whole approach and all the valuable tables of figures as well as their graphic representations, that she gives, are merely

illustrative of and subsidiary to the clinical interpretations that she is more concerned with.

The book is unique because it throws ample light on the so-called side-issues of clinical practice with the psychiatric patients, *i.e.* the sources of referrals, the motivations of parents and relatives who bring their children for help, their waning enthusiasm after the first visit, their unreasonable expectations of improvement, or of some magic-touch in the hands of the doctor, the difficulties of collecting follow-up information, the growing awareness of the serious consequences of the scholastic backwardness in children living in cities, acceptance of mental deficiency as a normal phenomenon in the rural areas, the adherence to an old-time belief that epileptics are in a state of possession by evil spirits and can be treated by ceremonies of exorcism, branding with hot irons and similar procedures. These are important culturally-oriented human issues which no clinical practitioner can possibly ignore.

In this connection, it will be interesting to quote what Dr. Hoch says about the parents' reasons for consultation in respect of mentally retarded girls. They are generally brought when they are in puberty. "The reason for the consultation is undoubtedly the idea that a girl, who in her dullness and with all her limitations may have been trained to do a few simple household jobs, definitely will have to be "patched" up and turned into something more presentable, if there is to be any hope of her being accepted by future in-laws !" And her general remark about consultation rings so true ! "The time when a child is brought for consultation is not significantly correlated to the moment at which the mental or emotional disorder becomes manifest, nor to the seriousness of the disturbance, but rather to practical utilitarian considerations.....What parents undertake seemingly for the welfare of their children, very often is not really devoted to the true needs of the child and the optimal development of all his possibilities, but all too often only aimed at making the child "useful" for something and, perhaps even more so, at turning the child into an asset, a source of pride, satisfaction, convenience, or even security and economic gain for the parents themselves." These utilitarian considerations are likely to encourage exploitation and this in turn may lead to conflicts and tensions expressing themselves, in various types of behaviour disturbances and personality deviations. Such a great truth has been said in such a simple manner without any embellishment or grandeur of theoretical overlay ! The book is full of such telling and pregnant statements of truth.

The book consists of five main sections. The first section is entitled "Introduction" in which the author discusses the need for writing this book as a means of stressing and promoting the welfare of children in the set-up of Indian socio-cultural and economic conditions. She refers to the paucity of certain types of child-welfare services and to the growing awareness of this deficiency among the people. Without undermining the significance of "survey" as a method of assessing the degree of help required, she proposes to present her experiences which she has gained in the process of rendering

practical help, in the field of child psychiatry. Her purpose is not to point out the incidence and nature of mental illness but "to provide some practical guidance for the further development of psychiatric and auxiliary services for children, by demonstrating what problems parents are already aware of and for what kind of difficulties they expect help." The second section deals with the characteristics of the total group of children who have been examined and guided by the author. The analysis of the characteristics is very comprehensive indeed! It covers twenty-four variables such as distribution according to sex, distribution according to age, reasons for consultation, diagnostic categories, local origin, community and caste, occupation of father or guardian, joint and individual family, lack of parents, heredity, number of siblings and position in the sibling-row, age of the mother at the child's birth, complications of pregnancy and delivery, the period of breastfeeding, toilet training, early neglect and separation, parental attitudes, physical defects in the children, former illnesses, education, problems of adolescence, children's interests, methods of examination and possibilities of treatment. Each of these variables has been discussed in terms of the findings on the group as a whole and gives evidence of Dr. Hoch's sympathetic understanding of the Indian family, its traditions, customs and mores embellished and integrated by her clinical insights—The section is supplemented by a number of useful tables and graphs on the total group of cases studied.

The third section of the book describes a number of individual diagnostic groups such as oligophrenia, post-encephalitic states, epilepsy, other organic states, neurosis, psychophysical infantilism, infantile psychosis and adolescent psychosis. The pattern of analysis of each diagnostic group is the same as followed in describing the characteristics of the total group of children in the second section. The author could have given a different chapter heading to each one of these individual diagnostic groups. Each of these sub-sections presents to working psychiatrists, social workers, pediatricians, child guidance workers, clinical psychologists abundant food for thought and discussion. It shows again and again Dr. Hoch's active investigative attitude and absorption of and identification with the Indian culture which is being affected increasingly by the socio-economic patterns of our growing democracy, and her outstanding ability to re-interpret the tenets of Western psychology in the light of this perspective. This is really illuminating and that, I think, is the greatest contribution of Dr. Hoch.

The fourth section deals with the various problems of juvenile delinquency. Her observations are again full of wisdom and sound common sense. She does not describe the patterns of juvenile delinquency as a sociologist would do, but lays stress on the psychodynamics of the problem in the emerging socio-economic conditions of the country. The final section summarises the results of the whole study in a lucid manner; it is followed by an index of case histories quoted, references, and a glossary of Hindi terms used in the body of the book. This may be useful not only to the foreign reader but to all others as well who are not conversant with these often-used terms and their implications.

This admirable book is written by an eminent psychiatrist who had her training in Basel, Switzerland. She had had experience in a psychiatric out-patient clinic for children and as a consultant to children's homes and reformatory schools before she became the clinical Director of Nur Manzil Psychiatric Centre at Lucknow where she worked for many years. She has a first-hand knowledge of the psychiatric and allied services available in our country and has contributed several scientific papers and articles on mental health in its many ramifications.

The book fills up a wide gap in psychiatric literature useful for students of psychiatric social work, pediatrics, psychiatry, clinical psychology, counselling, child guidance and public health nursing in India. There has been a deplorable dearth of adequate teaching materials including case histories illustrative of various age and diagnostic groups in the Indian set-up. Hence we have been forced to rely, so far, on Western books. Dr. Hoch's book, which provides valuable indigenous materials, both for teaching and for undertaking further research in the various areas, is strongly recommended not as a text-book in child psychiatry, but as a useful practical treatise based on years of work with Indian children and families having problems. Not only does it reflect an active, inquisitive and investigative outlook of 'researcher', it also combines in a wonderful manner the therapeutic and preventive attitudes of a dynamic psychiatrist. It gives a new direction and a new purpose.

(B.D. BHATIA)

Director

*Child Guidance Clinic
College of Nursing*

NEW DELHI

1st February, 1966.

Acknowledgements

My grateful acknowledgements are due to my fellow-workers at Nur Manzil Psychiatric Centre : doctors, psychologists, social worker, occupational therapist, nurses, attendants, office-manager, who helped to take care of the little patients and to collect the observations on which this investigation is based ; to the Board of Governors of Nur Manzil Psychiatric Centre for allowing me to utilize the case-histories ; to my colleagues in Lucknow, New Delhi, Bombay and Basel for kindly contributing figures for comparison.

My thanks are further due to Dr. C. G. Pandit, Director, Indian Council of Medical Research up to July 1964 and to Colonel B.L. Taneja, Director General, Indian Council of Medical Research since July 1964 and their staff for their interest in this book and their generous help in promoting its publication. Thanks are also due to Prof. B.D. Bhatia, Delhi Child Guidance Clinic, for his help in correcting the manuscript and his readiness to write a foreword.

My thanks are also due to the Manager and Staff of Cambridge Printing Works for all the patience and care spent on printing this book.

Last, but not least, I owe thanks to all the children and their parents who have granted me their confidence.

ALMORA,
Sept. 1962—Feb. 1963.

E. M. HOCH

CHAPTER I

Introduction

In the phase of intensive social, economic and cultural transformation through which India is passing at present, one frequently stresses that priority must be given to any planning and activity designed to promote the welfare of children. "The children are the Future of the Nation", is an often heard slogan. But while, about the future in general, one may say, either in carelessness or in profound faith : "Let the future take care of itself", the "Future" represented by our children is one which exactly cannot be left to take care of itself, but which needs a great amount of concern, care and foresight. Those who live in the "To-day", possibly still in regretful reminiscences of the "yesterday", have to be the guardians, the teachers, the healers and helpers of the "to-morrow", of a to-morrow about which they themselves are perhaps none too sure. They may hopefully expect something new, something better of this future, of these things to be ; and yet, with all their own limitations, their attachment to the old, to what has been, they are the ones who have to shelter and nurture this unknown future. So, unless they themselves are still capable of transformation, unless they have kept alive potentials within them, they will impress the stamp of their fixed habits, their rigid attitudes, on the yet plastic material of what is to emerge in the future generation, thus preventing it from growing into its own shape and destiny.

The problem then is that, on one hand, the older generation has to provide security through physical care, emotional concern, intellectual, moral and spiritual guidance to the children and adolescents who represent "the future of the nation", while at the same time it should give ample scope for freedom of expression and for the development of new possibilities in those it has to shelter. One can guess that, in trying to fulfil this double task, even those who may be aware of it, will easily err towards one side or the other and, at any rate, may feel considerable strain in being pulled between the two extremes.

Learned books and articles on child-psychology, on psychodynamics of adolescence, may be of little use to those who find themselves puzzled or defeated in their task of helping the young generation to grow up harmoniously. Bringing up children is not only a matter of "knowing", but primarily of "being". In each child, the parents invest part of their potential of existence. Their own attitude, their stage of maturity, their

openness to their own possibilities, or, on the contrary, their rigid imprisonment in a limited sphere of life or a social role, will necessarily pervade, however implicitly, the atmosphere in which the children have to grow up.

While, thus, the task of shaping the future of India through providing for its youth already is an intricate and troublesome one, even if a child is endowed with normal physical health, intellectual gifts and capacities for emotional balance, it becomes a serious problem, when, children with any handicap are concerned. Much has already been done in India for the physically disabled child. Children's hospitals and clinics, orthopaedic institutes and occupational therapy centres, homes and schools for the blind and the deaf and dumb, figure quite prominently in any list of social welfare agencies or medical facilities. The socially underprivileged and destitute child also is more and more provided for by orphanages, beggars' homes, institutions for children from criminal tribes, reformatory schools, day-nurseries, holiday camps, recreation-centres, play-grounds. Where, however, up to now, a serious lack is still to be felt, is the care for intellectually deficient and emotionally disturbed children and adolescents.

While in Western countries, any child welfare authority has a whole range of differentiated agencies and residential services to choose from, when faced with the task of providing for a problem child or helping his parents to care for his needs [See also HOCH (1)], facilities of this kind, like, for instance, special schools and residential homes for the mentally deficient, brain-damaged and epileptic children, child-guidance clinics, observation—and treatment—centres and homes for emotionally disturbed children, vocational training institutes for mentally and emotionally handicapped adolescents, are still very rare in India.

Some child-guidance clinics have been started in recent years, partly on the initiative of judiciary and correctional authorities interested in the implementation of the Children's Acts of their provinces. It seems, however, that the originators of schemes of this kind, perhaps influenced by Western text books, at times have some unrealistic expectations about the use to which such child guidance clinics will be put. They expect them in first line to be consulted by parents of children with behaviour problems, who could profit by such testing, advice and possibly psychotherapeutic help as can be given by psychologists and social workers. Many of them, however, find that their caseload consists to a great extent of children with mental defects or emotional disturbances that are the consequences of congenital or acquired damage to the central nervous system; and these can only be adequately diagnosed, estimated and perhaps treated by a medically trained person and in specialized institutions. Doctors, even the specialized paediatricians, on the other hand, often do not only lack the psychiatric training, but also the particular attitude and, perhaps most important the time necessary to deal with such children and their parents. Mental hospitals and psychiatric institutions, already overloaded with adults, usually do not provide any help, at least not in the form of residential treatment, for patients below the age of 15 or 16 years.

We therefore find a kind of "no-man's-land", as far as the care for mentally deficient and emotionally disturbed children and adolescents is concerned. Awareness of this lack certainly exists. In many conferences on child welfare, postulates for institutions of this kind are formulated quite forcefully in resolutions to be passed on to Government authorities. Practical initiative, however, does not seem to venture forward. At best, one will hear the almost stereotyped suggestion : "Let us make a survey first, so that we know, what we shall need."

A "survey", however, will presumably only trace the parents who are aware of their children's problems. These again, are the same ones who also may be looking, casually or even desperately, for help with their difficulties. The mere inquisitiveness of a surveyor will not satisfy their needs. The assurance that services will be planned and perhaps even established according to the result of the survey, will be a poor consolation. Problem children cannot be, so-to-speak, put into cold-storage until their turn on a legendary waiting-list of some planned or even only contemplated child-guidance clinic has come. They will go on developing in the already distorted fashion and, what first may only be a seemingly insignificant deviation from a straight path, will, even without changing the angle of deviation, by sheer length of persistence in the wrong direction, land them far away from what would have been a normal or optimal course of mental and emotional growth. Survey and research before undertaking any practical activity, will therefore not go far in helping to solve the burning problems that are already waiting for solution, and they may even disappoint, frustrate and estrange parents who would have been eager to cooperate in a practical venture, and thus may rather spoil than prepare the ground for services finally to be developed.

The author is of opinion that practical help, even if it has to be started with make-shift arrangements and little experience, is the primary requirement. If a service of this kind can be kept up and developed, it will automatically provide not only the material for a "survey", i.e. for an estimate of the needs for such services, but also ample experience of great interest for true research, a searching through of observations gathered in practice, in a spirit of scientific inquisitiveness and critical evaluation.

This would not only be the way dictated by necessity for quick help, but it is also the method by which psychiatric services for children have developed in the western countries. TRAMER, who is considered to be the initiator of "child-psychiatry" (not only as a discipline of medicine, but also as a currently used term), recently reviewed this development in a comprehensive article, (2) while already shortly before him, Leo KANNER, one of the leading child-psychiatrists of America, had undertaken a similar task in an article entitled "Child Psychiatry : Retrospect and Prospect." (3) According to these authors, who are amongst the foremost experts in the field, the first facilities for mentally an emotionally handicapped children established in Europe some 120 years ago, were charitable institutions for mentally deficient and epileptic children. In these, devoted workers gradually acquired experience and skill in dealing with retarded and disturbed children. Later, this led to more subtle investigations of minor deviations and to elaborations of theories, just as in adult psychia-

try much of the material which later was useful for treatment of neurotics and even for understanding normal human behaviour, was originally gained in observation and treatment of grossly insane patients. At the same time, through the fact that the worst problems were taken off their hands, parents, guardians and teachers became more open and receptive for attending to the less serious troubles of their children. Having learned to respect and trust the professional people who had proved their skill and devotion in rehabilitating human wrecks of the most pitiful type, they felt confident in approaching them with minor and more delicate difficulties. Experience with these more differentiated problems again led to new insights, which in their turn formed the base for further practical work.

Here in India, at the present time, the west has already supplied plenty of ready-made theories and instructions for treatment of the most subtle emotional conflicts. This second-hand knowledge may tempt one into starting one's efforts from the wrong end, namely to provide first for the minor behaviour problems, for which prognosis is more hopeful, and to neglect the more serious disturbances, for which efforts may be less rewarding, but which are the very problems that weigh most heavily on the patience of parents and teachers. But the natural sequence, dictated by the universal rule that the greatest needs claim to be attended to first, cannot be ignored, if adequate and efficient services for problem children are to be built up in this country.

It is the proposed method of research as literal "re-search" of experience gained in the process of rendering practical help, that has led to this publication. The result may bear marks of some of the defects of the method : The compilation of certain data may not be as complete as it could be in a planned survey. On the other hand, even in a well prepared survey, one may forget or neglect to inquire about certain factors, the importance of which cannot be guessed at the start, but which only reveals itself while the material is being worked through. Against this risk of incomplete or at least unsystematic information, the method of "re-search", i.e. of investigating the results of practical work already done, has its obvious advantages : Parents who came in their own and the child's interest, and who therefore know that any information they can contribute will help to solve their problem and not just to satisfy the curiosity of the investigator, will certainly be more inclined to reveal intimate secrets of family-life. The material thus gained, is therefore likely to provide not only a more detailed, but also a more profound view of the problems, particularly if these can be illustrated by individual cases that have been under prolonged observation and treatment. Apart from these explicit, definable advantages, one can say quite generally, that the spirit in which any search and research is undertaken, will have a great influence in determining the attitude and reaction of the object of investigation and therefore also what ultimately will be found as a result of the search. The merely scientifically oriented "surveyor" or research-worker may find interesting facts and figures, and, based on these, may even be able to formulate learned theories and suggestions. But it is the devoted worker with a deep interest in human life, to whom the living drama with all its sorrow and despair, but also all its joy and humour, will be revealed in its

true colourfulness, and who may, though perhaps only vaguely, grasp something of the ultimate problems and truths of human life, suffering and death.

Experience of this kind, formulated in a meaningful way and disseminated amongst those who plan and build up future services, may become more fruitful than mere theoretical constructs, even if they are based on the most exact and scientifically processed figures.

Furthermore, the analysis of material gained in practical experience with children of present-day India, will avoid the risk of blindly taking over theories and assumptions that have been formulated on the basis of conditions prevailing at various periods in the West and which may not necessarily fully apply to the Indian scene.

The material of 216 case-histories of children up to the age of 16, which the author proposes to review, has been gained by her and her fellow-workers between April 1956 and December 1961 at Nur Manzil Psychiatric Center, Lucknow, a private psychiatric institution under the auspices of the Methodist Church of Southern Asia and the Methodist Board of Missions, New York. Both, in and out patients' services are in first line intended for adult patients with emotional problems or outright mental illness. In the new buildings, inaugurated in February 1958, however, a special room for children's play therapy was installed. Up to October 1959, this facility was the only one of its kind in Lucknow and surroundings. Then, the Department of Neuropsychiatry of Lucknow Medical College opened a child guidance clinic and, about a year later, child guidance clinics, though with non-medical staff, were established at Agra and Varanasi. This, however, did not seem to reduce our figures for children to any degree.

The author, apart from her general psychiatric training in Switzerland (University Clinic and Policlinic for Psychiatry, Basel), has had some experience in a psychiatric out-patient clinic for children, as a consultant to children's homes and reformatory schools and as a member of the juvenile court of a Swiss city. On starting her work as Clinical Director of Nur Manzil Psychiatric Center, she found that her predecessor, Dr. Dagmar Norell, also a European psychiatrist, had not particularly encouraged consultations by parents of mentally handicapped children. The reason probably was that, without adequate facilities for residential treatment of such conditions as mental deficiency and postencephalitic states, any effort invested in such cases did not really seem to pay. Realizing that investigation even of those cases in which effective help was not possible, would gradually provide valuable information about the frequency and nature of the pathological conditions faced by harrassed and helpless parents, and therefore give useful indications for the planning of future services here in India, the author made it a point to register and examine, even if only shortly, every child who was brought to the Center. In this way, though the Center was never explicitly advertised as a child guidance clinic, it attracted a number of children which corresponds to 14 per cent of the total caseload.

It may be interesting to throw a glance at the sources of referral of these young patients. (Table I.) 34.1 per cent of them were brought by the parents or other family-members on their own initiative or through undefined channels. In 28.8 per cent, the parents and guardians explicitly mentioned that the Center had been recommended to them by former patients. 26.9 per cent had been referred by doctors, only 2.4 per cent by teachers and other school-authorities, and almost equally insignificant numbers of 2.7 per cent by psychologists, 2.7 per cent by friends, 1.9 per cent by religious leaders. The two most remarkable features in this scale of figures are perhaps the importance of direct recommendation by the "satisfied customers", the former patients and, remarkable in a very negative sense the small percentage of children who had been sent by teachers.

The apparent interest and willingness of the parents, who are responsible directly or indirectly on suggestion of former patients, for 64 per cent of the registrations, however, somewhat loses its impressiveness, once we consider the number of consultations for which the children were brought. It is a rather discouraging and depressing fact that 52.9 per cent of all Indian children (the 8 foreigners and Anglo-Indians have been excluded for most statistical purposes) never returned after a first consultation. 19.7 per cent came for 2 visits, so that there are only 27.4 per cent left who came for more than two visits. Though the number of those about whom we had no further news beyond a first consultation is somewhat reduced by a few cases in which we were informed about the result of our advice by letter, the fact remains that in the greater number of cases no follow-up of any kind was possible. (See Table II.)

The table on local origin of the children (Table III), to be discussed in detail later, shows that many of our little patients had been brought from outside the city and, for reasons of great distance, could not come back for regular treatment. It will further be seen later, when we resume these figures detailed according to diagnostic groups, that another reason for this apparent carelessness and lack of interest may at times have been the nature of the illness itself. In many cases, e.g. of congenital mental deficiency or acquired brain-damage, all we could do, was to give the parents a correct estimate of the nature of the child's handicap and of what they might reasonably expect of his further development, also to advise them about the best way they themselves could contribute towards the child's optimal development. Without special schools, occupational therapy centers or residential homes to refer them to, no actual treatment programmes could be offered. Still, what we may have achieved in some of these sad cases, may possibly have been to dissuade the parents from continuing their round of all available doctors, quacks and fakirs in the vague hope that some one might, after all, perform the hoped-for miracle or at least encourage them in their unreasonable expectations of improvement.

It seems that this pattern of consulting one doctor after another, often without even trying out the advice or instructions he offers, is not particular to parents or, quite generally, relatives of mentally disturbed patients only. The author has had occasion, in some other activity, to observe that even physically seriously ill children and adults

are seldom brought for a second visit, even if this involves no expense. It seems that in a good part of the Indian population, particularly in rural areas, there still rules a deeply rooted idea that the doctor's activity consists or at least ought to consist in one powerful and conclusive magic act. If the first contact with the healer produces no change in the illness, one concludes that either he did not have the power to heal or that, if he had it, one has not succeeded in gaining his favour by a suitable approach ! If ideas of this kind still govern people's behaviour even with regard to physical illness, for which usually at least some medicine can be given as a token of interest and—for the relatives' and patients' understanding—as a conveyor of the "magic power", coming back for continued treatment may seem even less worthwhile in cases of mental defect, for which the "medicine-man", i.e. the psychiatrist, may have nothing to give except his concern and advice.

In some of the parents, one felt that the motivation for bringing the child for consultation was perhaps only superficially tinted by really wanting to have the little patient "cured" or changed, particularly if this meant effort and change of attitude on the part of the parents too. The most important issue often seemed to be that, by consulting every possible doctor, one might appease one's own conscience that nothing had been left untried. The interest and concern of parents for their handicapped children, and quite generally again of relatives for their sick family-members, all too often is not measured by any personal effort at understanding and true care and devotion, but only in rupees spent on "treatment", perhaps also in terms of number, fame and local distance of doctors consulted.

Disappointing as this lack of opportunities for carrying through a complete treatment programme and also of gaining follow-up information may have been in many cases, we at least succeeded, even in the only interview often possible, in gaining some idea of the frequency of various forms of disease, of some of the factors contributing to them and of the attitudes and popular beliefs with regard to childrens' psychiatric disturbances.

If, on the following pages, numerous and detailed figures, tables and graphs, analysing various factors, are given, the author is quite conscious that this may deserve the serious reproach of trying to prove, by statistical pseudo-exactness, facts and hypotheses that can only be derived safely from much greater numbers. 208 cases (leaving away the 8 foreign and Anglo-Indian children), when divided up into diagnostic groups, and these again classified according to age, community, caste and other criteria, are whittled down to units so minute, that the laws of great figures cannot possibly apply any more. This is a serious source of errors, against which we have to guard all along. Some of the figures, e.g. about the distribution according to age, sex, diagnostic category, may have a certain validity in spite of the scarcity of the material, in view of the relative regularity with which they recurred yearly during the period under report. Others have found confirmation through control groups, e.g. amongst the adult patients or amongst the children themselves, in comparing diagnostically pure groups with other

groups in which the same diagnosis was mixed with an accessory trouble. Other figures again seem to correspond to those found by workers in other child guidance clinics.

In view of the smallness of our figures, we also have avoided using any elaborate statistical mathematics, which would only have reinforced the false impression of a numerical exactness which we are not in a position to give.

Even if the material on which the figures have been based had been far more extensive, one still would have to guard against one rash conclusion, which many people would only be all too apt to make. In discussing her psychiatric experiences in India with people from the West or even with interested Indians, the author has again and again had to answer the question : "Do you think there is more mental illness in India than in the West ?" or "Do you think mental illness is on the increase here in India ?" In answering this type of question, [See HOCH (4)], which of course could be asked in more precise and particular manner with regard to children and adolescents, one invariably has to point out that any figures about mental illness collected in any psychiatric institution, whether under Government or private auspices, will never give any conclusive idea of the actual incidence of any mental aberration in the total population. It may merely indicate that a certain mental condition, labelled by Western text-books as a psychiatrically recognizable deviation, also occurs in India and, secondly, that this particular type of deviation is no longer tolerated as fitting within the wide range of human variations accepted as "normal" within a family or a wider social group. Furthermore, it may show that certain portions of the population have been "enlightened" about the possibility of having abnormal conditions of this kind treated by modern medical methods instead of subjecting them to exorcism and other indigenous methods.

To mention just one example of figures which might be very misleading unless one keeps this caution in mind : Table III, on local origin of the young patients, indicates that the generally small proportion of children coming from villages is even smaller than average in the group of epileptics and mental defectives, while in the group of neurotics it coincides practically with the average for the total group, and in the group of psychotics it even exceeds this average. After discounting any possible influence of "small figures" in one or the other of these groups, one may still wonder about these differences, which apparently run contrary not only to theoretical expectation, but also to the common experience that practically every village has not only got its "village-pagal", but also its "village-buddhu". The explanation of the contradictory figures seems to lie in the fact that mental deficiency is still accepted as more or less normal or at least tolerable within a largely illiterate rural population, while epilepsy, though not accepted as normal, is regarded as a state of possession by evil spirits and treated by ceremonies of exorcism, branding with hot irons and similar procedures. An excited psychotic adolescent, however, will strike as abnormal in any surroundings and, gradually, the knowledge that such troublesome or even threatening patients can be treated or at least taken into custody by institutions of modern medicine, has also penetrated to the rural areas.

Why then, if our figures are so doubtful and have to be regarded with so much caution, has all the trouble been taken to analyse and present them?

For one thing, even the small figures can, in certain instances, at least point to a possible importance of certain factors in the material actually investigated. If they do not answer questions, they at least may lead to justifying already existing questions and perhaps to throwing open some new ones. In this way, they may have the value of a so-called "pilot-study", which sees as its task to explore avenues along which further research on bigger numbers might profitably proceed.

In addition to this, one has to remember, that a study of this kind at this particular time, may perhaps serve less to answer fundamental questions about the incidence and nature of mental illness, than to provide some practical guidance for the further development of psychiatric and auxiliary services for children, by demonstrating, what problems parents are already aware of and for what kind of difficulties they expect help.

Above and beyond this, judicious use of figures, coupled with the view into depth which single well-observed cases may grant, may, after all, draw attention to certain factors that apparently play an essential part in the origin or precipitation of mental and emotional disturbances. Thus, they can provide valuable clues for preventive work and perhaps, occasionally, also some deeper insight into normal and abnormal development of children and adolescents in this particular culture and the phase of transformation it is passing through. It is hoped that the material presented may help Indian psychiatrists, psychologists, paediatricians, teachers and child-welfare workers, who up to now had to rely mostly on Western text-books, to apply their knowledge to the special needs and problems of Indian youth. On the other hand, similar experts in the West, who nowadays show a keen interest in so-called "transcultural psychiatry", may find some of their questions answered by this publication.

CHAPTER II

Characteristics of the Total Group of Children

Before we attempt to analyse each diagnostic category separately and to illustrate it by individual case-histories, the group of children examined is to be characterized as a whole by a number of criteria. At the same time, while investigating any particular factor or feature, the difficulties inherent in this investigation and the methods used for gaining valid information will be demonstrated. Furthermore, the significance of any findings for the planning of future mental health services, as also certain problems of a general nature are to be presented. Unless specially mentioned otherwise, the figures given always concern the 208 Indian children only, excluding 3 Anglo Indians and 5 foreigners.

1. *Distribution according to Sex*

Already when, after one year's experience, the author examined the proportion of boys and girls amongst the young patients, she was struck by the definite predominance of boys. At that time, the proportion of boys to girls was 4 : 1 ; by 1959, i.e. after 3 year's experience, it had shifted to a ratio of 2 : 1, which now, after almost 6 years, has preserved itself fairly steadily, as the 140 boys and 68 girls represent a ratio of 2.06 : 1.

It may be interesting to note that this proportion corresponds fairly closely to the figures mentioned by the Annual Reports for 1955/56 and 1956/57 of the Child Guidance Clinic of the College of Nursing at New Delhi. (5) Between 1956 and 1961, the proportion of boys to girls fluctuates between 1.8 : 1 and 2.3 : 1. The fact that, with the exception of one year, these proportions registered at New Delhi give a little more prominence to the girls than our own figures, may be partly due to differences in the sources of referral. The New Delhi Child Guidance Clinic receives many patients through hospitals and Child Welfare agencies, i.e. people for whom any distinction between the sexes on grounds of cultural prejudice may have played less of a role than for the parents and other relatives, who, in our own material, were mostly responsible for bringing the children.

BASSA (6) in a recent paper, mentions a ratio of 3.1 boys to 1 girl in 2 child guidance clinics in Bombay, equally with very varied sources of referral, while for the

children he saw at the psychiatric department of a municipal hospital at Bombay, the ratio was almost 1 : 1 and, in his private practice, 1.7 : 1.

There is no generally valid reason to assume that the pathological states for which children are taken to psychiatric services should by themselves be more frequent amongst boys than amongst girls. The figures, particularly if detailed according to age and diagnostic groups (Graph I, Ia and Ib), confirm the impression that this difference in the numbers of boys and girls is not a consequence of some biological facts, but much rather the expression of the social phenomenon of giving preference to boys, which in this country, particularly amongst Hindus, is still prevalent. Actually we find that, amongst the Muslims, the girls make out slightly more than one third of the total, amongst the Sikhs they are more than double the number of boys, amongst the few Christian children the proportion is practically 1 : 1, while amongst the Hindu children the proportion of boys to girls rises to 2.4 : 1.

A more comprehensive analysis of this distribution according to sex can only be made in connection with other data, in particular taking account of age and diagnostic groups. In most of the tables and graphs which are to follow, the figures for boys and girls have been given separately, and any significant differences between the sexes will be mentioned when discussing these.

2. *Distribution according to age*

The youngest child examined was aged $1\frac{1}{2}$ years. The upper age limit has been chosen at completion of the 16th year, mainly so as to bring our grouping into accordance with the U.P. Children Act (7), which defines a child as "a person under the age of 16 years" (U.P. Children Act, Chapt. 1, 2, (4)). One may realize, however, that, with the vague notion of time many Indian people still have, the ages indicated may more often have been approximate than exact. We can therefore not guarantee that amongst the adolescents in the age-group 15—16, there may not have been some that had already passed the age-limit, while, on the other hand, some young people supposed to be aged beyond 16, and therefore classified amongst the adults, may actually not have completed their 16th year yet and therefore should have been counted amongst the children. Equally, any one age group may possibly contain children slightly older or younger. One can only hope that the unavoidable errors may have worked in equal measure towards the plus and minus side and that, therefore, to a certain extent, they may cancel each other out.

While the pyramid (Graph I) which presents the ages broken down into single years looks rather irregular and scattered, an attempt at summing up into three main age groups of equal spans of 5 years each : the pre-school child aged 1—6, the school-child aged 6—11 and the pre-puberty and puberty age from 11—16, shows more definite tendencies : (Graph Ia)

50 per cent of all children are contained in the age group 11—16 ; 31.2 per cent in the age group 6—11, and only 18.7 per cent in the lowest age group of 1—6 years. As one will see from the graph, this concentration in the oldest age group, is even more

pronounced where the girls are concerned, so much even that the ratio of boys to girls, which we found to be approximately 2 : 1 for the whole group, is changed to 1·6 : 1, while in the age group 11—16 it amounts to 2·25 : 1, in that of 1—6 even to 3·8 : 1. (Graph Ia)

What can we conclude from these figures? Is there perhaps any age at which girls are more vulnerable than boys? Does the critical phase of adolescence set in earlier in girls, so that, if we could take into account the whole period of adolescence, up to 18 or even 20, the figures might balance out again, as by that time the boys might also have reached this critical age? This latter question may possibly be answered later, when the data about our adult patients will also have been worked through. The other point raised may find at least a partial answer, if we try to divide our material up into a group of those cases, in which the mental or emotional disorder is due to a congenital deficiency ("paidaishi") or an acquired, anatomically and clinically demonstrable damage to the central nervous system, which we shall mark with "congenital and organic" (or for short "congenital—organic"), and a second group, in which the disturbance is due to psychological factors, in other words : in which only the function, but not the structure of the nervous system is affected, and which therefore will be labelled as "functional". If we perform this division (Graph Ib), we actually find a marked accumulation of girls aged 14—16 in the "functional" group, to which, however, a moderate "top-heaviness" of the pyramid also corresponds on the boys' side. On breaking up the figures further, we shall see, (Graph Ic) that, though already the group of neurotics shows this pattern of broadening out of the highest age-brackets, the girls very definitely predominate in the group of psychotic adolescents. Amongst these girls, there are 4 in whom the breakdown has been precipitated by an early marriage, while amongst the girls who only went into a neurotic disorder, several were worried about prospects of approaching marriage. Others, amongst the Muslims, who contribute a high percentage to the neurotic group, were reacting to the restriction of their life sphere on their having to enter "purdah". The start of menstruation as such, without the outward accessory consequences of physical maturity just mentioned, though often a source of anxiety and dismay, does not seem to have affected any of the girls decisively and exclusively. Amongst the boys, except for one adolescent from a village, who was married and responsible for the family-farm, there were none in whom being burdened with similar social consequences of physical maturity at so early an age can be said to have contributed to the emotional disturbance, while in many cases the upsetting effect of puberty as such is fairly obvious. The predominance of girls in the age group 14—16 therefore seems to be more due to social and cultural factors, which tax a girl's physical maturity earlier than that of boy and not so much to a greater lability through the biological changes of puberty as such.

In the functional group, one will naturally expect some fluctuation in the frequency of cases in the various age-groups, for instance according to FREUD's theory of a first phase of sexual development and curiosity up to the age of about 4, the consequent "latency period" and the revival of sexual interest at puberty age. If we allow for a

shift in age due to the fact that most children are not brought for consultation immediately when some trouble starts, but often only after some disorder has had time to become fixed, or even only when by chance the parents may hear about some possibility of help, at least the male side of the age-pyramid might almost fit in with this theory, while the girls do not quite seem to conform to it. Other authors, amongst them the already mentioned Swiss child psychiatrist M. TRAMER, consider as the critical phases the age of about 3, which he calls the "affective crisis", the "phase of reason" at the age of 7—8 and then pre-puberty, which here in India we might place at the age of about 11.

Though possibly any such "critical phases" may have had their influence in setting the time for the manifestation of an emotional disturbance in individual cases, we would probably be far too optimistic in assuming that any such biological or otherwise intrinsic factor could be significantly reflected in the shape of our age-pyramid, except perhaps where its broadening out at puberty age is concerned. Even this peculiarity of the curve, as we have already shortly mentioned, is not entirely due to puberty as such, but rather to its social consequences. Considering this, it might pay to investigate, whether any other irregularities of the age distribution could be due to social rather than to biological factors.

For this purpose, we can profitably turn to the age pyramid for the organic and congenital cases and in particular to that for oligophrenia (Graphs Ib and Ic). As oligophrenia, or in other words mental deficiency, is *ex definitione* a congenital condition, the age at which a child is brought for consultation ought to correspond to the phase of development at which the lack of intellectual abilities becomes manifest. This again depends on the higher or milder degree of the defect. While an idiot (i.e. the most severe degree of mental deficiency) can already be identified during the first months of his life, an imbecile child (medium degree of mental deficiency) may only strike his parents as abnormal, when development does not progress beyond the stage of mere conditioned reflexes and automatic learning, which a normal child should leave behind at an age of 10—12 months. The moron finally (least severe degree of mental deficiency), may only be discovered at an age, when his intellectual abilities are taxed more severely by new situations and requirements, e.g. when he is supposed to go to school.

Though the youngest amongst our mentally deficient children are cases in which the defect is very marked, we, however, find imbeciles and idiots even amongst those children who were brought at quite advanced ages. In fact, if we look at the age pyramid for the oligophrenics and for all congenital and organic cases, we find that, after a first jutting out at the age of 4—5 for boys and a second broadening for both sexes at 7—8, it is much more uniform than that for the functional cases. This makes one suspect that the question, whether a mentally handicapped child is brought for consultation, is not so much a function of the degree of his illness or handicap, nor even of the time at which the defect may be discovered by the parents, but very often only an indication of the family's knowing about some possibility of help and, above all, of their willingness to spend money, time and interest on the child concerned. This again may depend on what one hopes to gain by the investment. As long as a child merely stays at home,

a defect may be overlooked or tolerated. When, however, a time comes, at which the child has to face sectors of society outside the family, not only considerations of family prestige, but often also reflections on future economic usefulness may begin to count. Such moments of emerging into a wider world, at which a defect may not only have a chance of manifesting itself more clearly, but also of becoming more of an embarrassment and a burden to the family, are, above all, the time for starting school and, later on, the approach of marriage for girls and the choice of some occupation for a boy who cannot engage in higher studies. It might indeed be highly plausible to correlate the accumulation of boys at the age of 4—5 and of both sexes at 7—8, both in the pyramid for oligophrenic and all organic and congenital cases, with parents aspirations of sending children to school. One might even suppose that the broadening of the functional curve at the age of 4—6 might mark a similar phase, occurring earlier in these intellectually well-developed children. Whereas up to the age of 7—8 one might reasonably expect that a retarded child might still “catch up”, his refusing to learn at an age, when most other children are well started in their primary education, may provoke more concern.

Again, though less pronounced than in the functional group, we find a certain top-heaviness in the age pyramid of organic and congenital cases. On inspecting individual case-histories of this group, we find that in some cases puberty itself, with its influx, of new, strange forces, which the damaged brain cannot sufficiently control, leads to a crisis, moving even previously careless or resigned parents to undertake something. In other cases, however, particularly amongst the girls, the reason for the consultation is undoubtedly the idea that a girl, who in her dullness and with all her limitations may have “passed” within her own family, where she may have been trained to do a few simple household—jobs, definitely will have to be “patched up”, and turned into something more presentable, if there is to be any hope of her being accepted by future in-laws !

This observation that the time, when a child is brought for consultation, is not significantly correlated to the moment at which the mental or emotional disorder becomes manifest, nor to the seriousness of the disturbance, but rather to practical, utilitarian considerations, already reveals to us to a fact which we shall have to point out again and again in the course of this study, as it ought to give food for serious thought: What parents undertake seemingly for the welfare of their children, very often is not really devoted to the true needs of the child and the optimal development of all his possibilities, but all too often only aimed at making the child “useful” for something and, perhaps even more so, at turning the child into an asset, a source of price, satisfaction, convenience or even security and economic gain for the parents themselves. And it is perhaps this very utilitarianism, which no longer respects anything in its own right of existence, but wants to use and exploit everything, that is amongst the foremost evils of our time.

One may of course object that, at least in traditional Hindu culture, the function and place of a son *is* to hold up and perpetuate the pride, honour and prosperity of a

family, while a girl *has* to be prepared for her life with the in-laws. True, these are valid and recommendable ideals, but only as long as they figure within their authentic frame of reference : a society completely based on strength and coherence of the family as an organic unit, which not only imposes duties on its members, but also provides support and security for them. Once, however, this system starts to disintegrate under the influence of more individualistic ideals, there is a great danger that, while turning one eye towards this new order and trying to get the best out of it for oneself, one will still squint back and try to save any possible assets out of the ruins of the old structure. The confusion of values resulting from such double adherence, in which everyone seeks his own advantage, wherever it may offer itself more easily, may be responsible for much of the conflict between the generations : the dissatisfaction and disappointment of the old, and the arrogance, restlessness and rebellion of the young.

3. *Reasons for consultation*

The reflections on distribution according to age, have already taken us deeply into diagnostic differentiations. It is therefore, high time that we should present the different diagnostic categories into which the children have been divided up. What in practice we are first presented with, however, is not a ready-made diagnosis, but a set of symptoms or problems, which the parents or other persons have noted in the child or of which possibly a child, particularly in the older age group, himself complains.

Though these symptoms and their combinations are of course closely related to the type of disease, a table in which the symptoms or rather the reasons for consultation are listed for the whole group of children, will have its value even apart from diagnostic considerations. It will show us, which are the most frequent problems that alarm and worry parents and guardians and may give some indications with regard to the needs any new child guidance clinic will have to provide for.

In a table of this kind, we can only indicate the frequency with which any particular problem or symptom occurred ; but it will not necessarily reflect, which particular trouble in first line stirred the parents' concern to an extent that they resorted to consultation of a psychiatric center. We have, however, tried to list the reasons for consultation in a sequence more or less corresponding to the urgency and priority with which the various problems were mentioned by the parents.

As one will see in Table IV, this sequence does not quite coincide with that dictated by the frequency of symptoms. Defects or retardation in intellectual capacity and performance, no matter whether organic-congenital or functional cases are concerned, were usually the first ones to be mentioned. Behaviour problems, which accompanied mental defect in many cases (e.g. 51 out of 64 mental defectives), though more frequent, were often only added on second thought or even elicited only by our inquiries. Convulsive fits of course are also likely to impress parents as serious. They were, however, not always indicated in first line, and sometimes even deliberately left unmentioned, in some cases apparently out of some superstition, in other cases so as to test the cleverness of the doctor by seeing whether he would find out this important feature.

Signs of insanity also naturally get priority in parents' accounts of symptoms. As, however, they only apply to a very small group, they have been placed in fourth rank. The following three items: motor handicaps, delinquency and sensor handicaps, (blindness, deafness), were mostly mentioned as accessory issues and not as the essential reasons for consultation. We have tried to add one column concerning the frequency of subjective symptoms, i.e. troubles and problems indicated by the children themselves. Difficulty in intellectual performance, when due to lack of concentration or possibly to excessive parental ambition, of course, would be one of them, but has already found its place amongst the objective symptoms. There remain anxiety and depression as the main complaints felt and expressed by the children themselves. Reliable figures for these were only obtained in the functional group. In the children of the congenital or organic groups, such subjective symptoms were either lacking or, if they were present, the children were unable to express them.

Our attempt at listing these reasons for consultation for the total group can hardly claim to be very instructive. One will see later that similar, but more differentiated tables for each individual diagnostic category are far more revealing. The purpose for which this table (Table IV) was included, was to show, what problems are most likely to preoccupy parents' minds and to move them towards seeking help in their task of bringing up children. The expectation with which originators of child guidance clinics often set out in their tasks, namely that they will be consulted by parents of children with behaviour problems, seems to be justified by the numerical predominance of behaviour changes, which were listed in 75.9 per cent of the cases. As already mentioned, however, disturbances in intellectual capacity and performance,—and these include not only congenital and organic mental defects, but also functional impairments, due to lack of concentration, emotional dysbalance, general retardation of development,—were often expressed with greater priority and urgency. In this phenomenon we can certainly see a reflection of the great stress which nowadays is laid on intellectual development, performance and achievement. The intellectual failing of a child, whether organic or functional, is much more likely to rouse his parents into concern and action than any change in his emotional, social or moral development. We have mentioned earlier that, rather against expectation, mentally deficient and quite generally, congenital and organic patients were brought relatively less frequently from villages than children with functional disturbances. Perhaps this may be taken as a sign that, in the old order of things, where even a mentally handicapped child found some kind of security, acceptance and perhaps even a respected function within the joint family, less importance was attached to intellectual "brightness" than in "modern society". In a new order in which people have, so-to-speak, to live by their wits, any lack of ability to gain recognition by intellectual performance, is necessarily thrown into the foreground as a problem of great importance. This again shows, that the frequency with which any particular trouble is brought before the psychiatrist may not correspond to the actual rate of incidence, but rather to the value set on intactness of any particular function and the tolerance for any defect in it, which is characteristic for a certain cultural environment.

4. *Diagnostic Categories*

In attempting to form neat and comprehensive diagnostic groups, two main difficulties were met with : that of definition,—a more theoretical and academic one,—and that of diagnostic combinations and overlapping of groups. While, for some purposes, a rather wide grouping, leaving aside theoretical distinctions, may be more expedient, certain characteristic features can only be demonstrated by a more subtle division. This difficulty had to be overcome particularly with regard to the group which we have called “congenital and organic.”

For the layman, or even for the educational expert who deals with mentally backward children, mental deficiency will designate inability of a child to develop his intellectual functions according to his age. In a strictly psychiatric sense, however, the term “mental deficiency” or “oligophrenia” only applies to a limited capacity for intellectual development which is present right from birth. This again would include certain hereditary conditions, others that may be due to intra-uterine brain-damage and even,—though already in a less strict sense—, consequences of injuries sustained during delivery. Any postnatal impairment of the central nervous system leading to an intellectual defect, such as infections of the brain and its wrappers (encephalitis and meningitis), head-injuries, consequences of frequent epileptic fits, should strictly speaking count as “dementia”, i.e. loss of a once present intellectual potential, and not as a primary mental deficiency. This fine distinction, which for practical purposes may often be negligible, may have its interest, when one is trying to investigate causes and perhaps to plan prevention of intellectual disabilities. One may, however, not always be able to establish an accurate division. Unless the parents have observed a child very exactly, with some notion about the normal sequence of developmental stages, perhaps gained from watching previously born children, it is often difficult to state, whether some signs of brain-damage found on neurological examination date back to a prenatal stage, or whether they might possibly be the consequence of some fever or injury in early infancy. Furthermore, a nervous system which is constitutionally weak or which has already been impaired before or at birth, may also be more susceptible to postnatal damage through infection or other influences, so that congenital and postnatal factors can be combined.

We have tried to assemble, in the group of oligophrenics, children whose intellectual development had been retarded right from the start, in whom no dramatic event, like high fever, possibly with convulsions, or an accident with brain-injury, made one suspect essential postnatal damage, and in whom any signs of an organic lesion of the central nervous system did not point to one of the conditions summed up under the name of “infantile cerebral palsy”, which even in its prenatal form has more affinity with the encephalitis group than with oligophrenia in a strict sense.

Even then, there remained a number of cases, in which a defect, noted since birth, had later been complicated and exacerbated by some cerebral infection or by the occurrence of convulsive fits. These cases have been set apart in “combined groups”.

(Table V). The question then arose, which condition in any combination should be regarded as the main diagnosis : whether the trouble most insisted on by the parents, e.g. in a mentally deficient child not the lack of intellectual capacity, but perhaps some convulsive fits or even behaviour problem, should be taken as a criterion, or the condition, which from a medical point of view was the more serious one or, a third possibility, the disease which had manifested itself first and which presented the most basic disturbance on which perhaps a second trouble had merely superimposed itself. We chose mainly the last mentioned procedure. Oligophrenia, as an essentially congenital defect, was regarded, wherever it occurred, as the basic diagnosis. One will therefore see, that this group is the biggest one, as the figures, 48 boys and 16 girls, used for most statistical purposes, also contains all combinations with the other groups. The pure cases of oligophrenia, not complicated by any other disturbance, only amount to 28 (plus one Anglo-Indian boy), of whom 18 boys and 10 girls. 4 cases were combined with postnatal encephalitis, 12 with epilepsy, 19 with neurosis (of which 2 each also with encephalitis and epilepsy), two with infantilism, one with infantile psychosis and 2 with adolescent psychosis. In these latter groups, the combination of mental deficiency with some functional trouble, the reason for consultation was often a behaviour disorder or an exaggeration of the mental disability through emotional factors, without which the parents might never have thought of seeking help for the feeble-minded child. In spite of this, the functional trouble had to be regarded as secondary, as in most cases it would probably not have originated without the basic mental limitation, which may have exposed the child either to excessive protection and pampering or, on the contrary, to exaggerated demands and ambitions on the part of the parents. Wherever it was expedient to do so, this group of functional superstructures on a basis of mental deficiency or any other organic condition, has been presented separately and, at times, used with advantage as a control-group.

In the second group, all those cases (25 boys and 10 girls) have been gathered in whom an intellectual defect, some behaviour disorder or even the occurrence of convulsive fits dated back to a well-marked illness with high fever, with alteration of consciousness, possibly with symptoms of paralysis and disturbance of vision, sometimes associated with convulsions, altogether an acute illness suggesting the diagnosis of encephalitis, either in its own right or accompanying some such disease as smallpox, typhoid or influenza. A few cases in which the acute illness had been diagnosed as meningitis, have been added to this group. Again we find some combinations : 4 cases already mentioned under oligophrenia, 2 in which the acute illness was superimposed on an already existing epileptic disorder (in these 2 cases an exception was made from the rule of taking the more original diagnosis as the main one !) and 9 in which the postencephalitic behaviour disorder seemed to have been accentuated by neurotic reactions to the consequences of the illness as such or to the attitude of the family.

On coming to the group of epileptics, we find ourselves in the somewhat puzzling situation of having to present only 19 cases, 13 boys and 6 girls, that have not already been summed up under the headings of oligophrenia and postencephalitic states. While

thus, according to the table summing up main symptoms (Table IV), 67 children or 32.2 per cent of the total, suffered from convulsions at one time or other of their lives, less than one third of this number are actually to be found in this small group. Of these 19 cases again, which can probably mostly be considered as what is called "genuine epilepsy", in contrast to the symptomatic epilepsies associated with an obvious organic brain-damage, 6 present either combinations with neurotic features or, particularly in cases in which the fits started at puberty age only, are suspect of being of "psychosomatic" nature, i.e. the direct result of some neurotic tension on a hyperexcitable or possibly slightly damaged brain.

There remains a small group of 3 Indian boys, one Anglo-Indian girl and a foreign boy, whose organic trouble did not seem to fit in with any of the 3 categories already mentioned, as the impairment of the nervous system was neither due to an obvious encephalitis, nor had it caused any significant mental defect or tendency to convulsions. We have kept these few cases separate under the heading "organic". Two of them, one Indian, one foreign, again showed signs of a superimposed neurotic disorder.

Coming now to what we have called the "functional disorders", the figures usually given will only indicate the "pure" cases, as in any combination the functional disorder will be the secondary one and the case therefore listed in one of the congenital and organic groups. The concept of "pure", however, has to be limited in so far as in these functional groups we find some children in whom discrete signs of brain-damage were found. Wherever this had escaped notice previously and where there was no history of a decisive illness or other dramatic happening after which any obvious change had been observed, these signs of organic damage were regarded as accessory and not as basic, and the cases therefore listed in the "pure" functional groups and not amongst the combinations.

By this system of leaving combined cases in the group of the more original disorder, we have been able to separate the figures in a way that allows them to be summed up to the correct total of all children, while, for special purposes, they can be added to the group of the secondary combined diagnosis.

Some explanation has to be given now about the 4 groups into which the functional cases were arranged. The distinction between neurosis (33 boys, 21 girls, plus 1 Anglo-Indian and 2 foreigners) and psychosis (8 girls and 3 boys), —the first one a mere "distortion" of a still more or less integrated personality, the second a complete disruption—, was not always easy to make. It is well known that in the phase of puberty, with all its plasticity and potential for growth and transformation, many phenomena that at a more advanced age would be regarded as highly pathological, can still pass for transitory features which might fit into what one sometimes calls "puberty crisis". We have therefore avoided, as far as possible, labelling any of the young patients as psychotic. Even so, 11 cases and 2 further ones combined with oligophrenia, remain, in which either the intensity and type of the symptoms, their persistence, or the later development which in some cases we could follow-up, quite definitely suggested a schizophrenic disorder.

Amongst the neurotic adolescents, there are quite a few whom some other examiner, asking for less strict criteria, might have regarded as psychotic and whom the author herself might have to place into the psychotic group, if more thorough investigation and a follow-up a few years later had been possible. These cases have been marked as "borderline psychosis".

Other authors, on the contrary, would have hesitated to apply the general term "neurosis" to many of the cases, which they might only have termed as "behaviour disorders", "developmental crises" or "abnormal reactions to environmental stimuli". The term "neurosis", as used by us, is to be understood more as a rough differentiation, on one hand from congenital-organic conditions, on the other hand from psychosis. As such, it may well include conditions that may not deserve the name in a stricter sense. One will see later that, within this group of neurosis, we have set aside some cases labelled "neurotic development", which perhaps are the only ones certain other experts would really regard as "neurosis" in the strictest sense.

The two small groups named "infantilism" and "infantile psychosis" might perhaps have been absorbed into the categories of neurosis and psychosis respectively. One will, however, see that the very definite age distribution (Graph 1c) justifies a separation of infantile and adolescent psychosis. Only one of the subjects in the group of adolescent psychotics had shown definite peculiarities already in infancy, but, as far as we could make out from the parents' accounts, not of a type that would have justified a diagnosis of infantile psychosis at that time. Amongst the children classified as "infantile psychosis", on the other hand, there is one boy, who was first examined at the Center at the age of 7 in 1954, already then definitely psychotic and "queer" since infancy, and who later was followed-up by the author from the age of 10—13, when there was no doubt that he was developing into a schizophrenic.

This group of "infantile psychosis", as we have cautiously named it, as the other term, "infantile autism", might not be regarded as covering quite exactly all of the cases, is of particular interest, as the causes for this serious behaviour disorder of small children are very little known yet and a matter of great controversy. So, any observations, particularly if they come from a culture from which up to now little has been published about incidence and form of mental illness, may represent a valuable contribution to this subject, an additional reason, why this group of 12 boys and 4 girls, plus one Nepali boy, should be dealt with separately. Again, other authors might be even more reserved than we have been and use the term "developmental crisis" rather than the somewhat sinister label "psychosis" for cases of this kind.

The group entitled "infantilism" or more explicitly : "Psychophysical infantilism", finally, holds 6 children only : 3 boys and 3 girls, plus one foreign girl, who were brought mainly for intellectual retardation, but whose whole development : physical, emotional and intellectual, was behind age. In some of these cases, premature delivery, slight organic damage to the central nervous system or a recent severe physical illness seemed to account at least partly for the retardation ; in others, the reason appeared to be

more psychological. As infantilism is not a typical or even exclusive expression of neurotic distortion at an early age and as, on the other hand, it had to be distinguished from the group of mentally deficient children, as, furthermore, it shows some affinities with the group of "infantile psychosis", its separation seems to be justified.

Table V sums up the numerical distribution into the various diagnostic categories and their combinations.

It might have been tempting to draw some conclusions from the percentual distribution of the children amongst the different diagnostic categories. But, as we have pointed out earlier, it would be quite inadmissible to take such figures as a measure for the incidence of similar disorders in the total population. All these figures can indicate, is the degree to which parents are aware of certain defects and disturbances in their children and to which they are informed about possibilities for treatment and willing to spend money, time and interest on availing themselves of such opportunities.

Comparison with figures from other child guidance clinics might have given some clue about the general validity of our observations. Unfortunately, the nomenclature is not standardized, and the few figures which we could gather from annual reports, papers etc. vary considerably in their diagnostic terminology. Wherever comparison seemed to promise reasonably reliable results, or where it was of particular interest, we have used the figures available for this purpose.

Even if we take account of all these cautions just mentioned, there is one figure that strikes one as rather remarkable, namely that for "infantile psychosis". Absolutely, it may seem rather small with only 16 Indian children and one Nepali boy. But if one learns that, in a very recent publication, in which the case-histories quoted correspond very closely to our observations, the German author (G. Bosch) (8) in charge of the department of child psychiatry of the University of Mainz, can only report on 13 cases of this kind observed during a period of 8 years, while our 17 cases were registered in the span of less than 6 years, in a country where child-psychiatric services are, as yet, much less popular, one may be justified in assuming that our figure is not quite negligible. We shall have occasion to come back to it, when discussing this group of "infantile psychosis" in particular.

Graphs Ib and Ic give the distribution according to age within the diagnostic categories and, summed up, in the congenital-organic and in the functional group. Some of the peculiarities of the age distribution already mentioned earlier, may now be better appreciated.

In the following paragraphs, dealing with further criteria of the total group, figures and graphs will usually be given broken up into the diagnostic categories just described. The totals for each category, unless otherwise mentioned, will always contain those combined cases only that have not already been counted in a previous category, which means, to sum it up again : that the oligophrenic group contains all

possible combinations, the postencephalitic one only those with epilepsy and neurosis, the epileptic and organic groups only combinations and associations with neurosis, whereas the total figures for the functional group only contain "pure cases". In some tables, the figures for all or certain categories of combinations with each group have also been given separately.

The definition and differential-diagnostic characterisation of each individual group will be found in the corresponding chapters of Part III.

5. *Local Origin*

A commentary on the local origin of the children examined is not only of theoretical interest, as it may give some idea, if not of the incidence, but at least of the local variations in awareness and tolerance with regard to children's psychiatric disorders. It may also provide some suggestions for the development of future mental health services.

On one hand, as long as facilities and, in particular, trained experts are scarce, one will naturally tend to centralize any planned services in a few big cities. Our table (Table III), on the other hand, shows that the need for child guidance clinics is also felt in smaller towns. (Most of the patients from "towns" in UP in Table III, apart from some cases from Kanpur, Allahabad, Varanasi, Agra, are from small country towns). The number of people coming from outside big cities, from UP as well as from other provinces, are presumably only a small proportion of those who may have been looking for help, but who may not have heard about the possibility available at our Center, who may have consulted other services or who, if they knew about the existing facilities, could not afford time and money for a long journey.

The fact that more than half of the children were brought from outside Lucknow at any rate suggests that there is scope for child psychiatry outside the big cities too.

Any centralized institution can be of little help to those not residing in its immediate vicinity. Even where children living in the same city are concerned, the problem of suitable escorts for repeated visits is a quite serious one. It has also been mentioned in the Annual Reports of the New Delhi Child Guidance Clinic (5) as an important reason for the frequent dropping out of cases before any therapeutic result or even a full diagnostic evaluation had been achieved. If such difficulties exist, in place, where the local distances are negligible, continued treatment and efficient follow-up will be even more impossible, if patients of a big area, possibly a whole province or at least several districts, have to be served by one centralized clinic. Until enough trained experts are available to staff small centres at least at district level, one may have to think of mobile units.

This system has been used for instance, to great advantage and with interesting results, in the Canton du Valais in Switzerland. The Director of the public mental hospital of this mountain province, Dr. Reponds at Malévoz, one of the well known

protagonists of the mental health movement, built up his "service médico-pédagogique" in the mountain village, where the mental hospital happened to be situated, and made it available to the children of many of the out-of-the-way mountain valleys by sending the experts and also the trainees of his institution on tour. In other parts of Switzerland, the experts stationed at observation homes and other residential services for maladjusted, mentally deficient and epileptic children hold weekly or even more frequent consulting hours for out-patients, either at their institutions or, if these are difficult to reach, in some easily accessible locality of a neighbouring town.

Direct contact with the locality from where the child comes, will also enable the doctors, psychologists and social workers to estimate environmental factors better than this is possible through a hurried visit from far away, which may add, to the original trouble, awkwardness, anxiety or even stupor on facing the unaccustomed rush of city-life.

A figure of particular interest : the proportion of children brought to Lucknow from villages, inside and outside UP, has already been shortly mentioned previously. It may pay to take a closer look at it. In evaluating the figures given, we have to realize that, according to the 1961 CENSUS (9), 81.7 per cent of the Indian population live in villages ! For our total group, the percentage of children from villages is 8.2 per cent. Significantly higher than this percentage, are the figures for infantilism with 16.6 per cent and infantile psychosis with 12.5 per cent, slightly higher those for adolescent psychosis with 9.1 per cent and for the postencephalitic group with 8.5 per cent. One may object that all 3 first named groups consist of very small figures, so that even one stray child brought from a village may represent a considerable percentage. This argument is quite valid. Still, if we take the functional group as a whole, we find a percentage of village children of 9.2 per cent, while in the congenital-organic group the corresponding figure is only 7.4 per cent, even then containing 2 cases that were brought for neurotic complications of the basic disorder. As already mentioned previously, the low percentage of epileptic children brought from villages, only 5.2 per cent, is rather striking. The reason for it is probably that, in a rural setting, convulsive fits are often still considered as due to possession by evil spirits and therefore treatment by methods of modern medicine out of question. We have seen several children who had their foreheads branded by hot irons or ornaments, and one little girl had been fed on a suitable dose of bed-bugs each week for some time. The same reason : fear of evil spirits and their possible revenge, or the idea that modern medicine had nothing to offer for such fits, may have determined the behaviour of some of the parents who actually came to consult us, but who did not mention the fits, representing some associated disorder, such as mental backwardness or behaviour disorders, like running away, fits of temper, as the main cause for consultation.

In connection with local origin, we also tried to find out, how many of the children had been subjected to migration or even to the fate of a refugee. Taking all those together who had suffered either one change, several changes or complete uprooting on Partition, we find a percentage of 9.1 per cent of the total, 10.3 per cent for the

functional group and 8.2 per cent for the congenital-organic group, the latter figure again containing some combinations with functional complications. If one wants to attach any value to this difference in the figures, one might therefore conclude that changes of environment in childhood have some correlation with the occurrence of functional psychiatric disorders. The actual importance of migration, however, can only be evaluated in the individual case. We may have occasion for giving examples of this in later chapters.

While amongst our grown-up patients, we have a considerable number of Pakistan refugees, (the exact figure cannot be given yet), in whom insecurity, loss of social and economic status or even shock through witnessing riots and scenes of violence seem to have contributed to functional disorders, the rate amongst the children, with 1.9 per cent, is very small. (Table III) we have, however, to consider that, taking 1947 for the year of the main exodus, by 1956, the year our observations started, only children aged above 9 could have been old enough to have experienced the uprooting, and even then only at an age below 7. By 1961, nearly all the children who had witnessed the flight from Pakistan even at an early age, had grown beyond the age of 16. One may argue that neurotic tendencies could have been promoted not only through the change in surroundings and the whole upsetting atmosphere as such, but perhaps just as much or even more through the resulting insecurity and anxiety of the elder family members, who may have had to struggle for years to build up a new existence again. These, however, are again considerations that could only be fully appreciated in individual cases. On the whole, one may probably be justified in supposing that a child who is well embedded and sheltered in his parents' care and affection, will stand a change of local environment more easily than any change within the family, while remaining in the same locality, particularly at pre-school age, when contacts with the outside world are still negligible.

In the one neurotic girl who, examined at 15 in 1960, had witnessed flight from Pakistan at the age of 2, the factors responsible for the disturbance do not seem to be in any way related to the refugee situation. Of 3 mentally deficient children of Pakistani refugees, one is an idiot by birth, therefore not likely to have suffered emotionally, when he faced migration at the age of 2-3. One boy was born shortly after the family arrived in India. The mother was upset not only by the refugee situation itself, which she had to undergo while pregnant, but also by the death of 3 of her older children, due to smallpox, on the journey from Pakistan. It is possible that the somewhat clinging, pampering attitude of this severely deprived mother may have accentuated the helplessness of this boy and led to the neurotic superstructure which we stated on examination. A third mentally deficient boy who, at the age of 15, was so much generally retarded that we termed him as infantile in addition to his mild mental deficiency, was aged 5-6 at the time of Partition. In his case, some physical malformations and neglect by a compulsive mother, who found her visits to the temple more important than taking care of her children, probably contributed far more to his backwardness than the refugee situation.

This insignificant yield in cases that might have suffered early emotional shock or frustration during the period of Partition and all the upheavals connected with it, is of course no proof that an uprooting of this kind cannot leave its lasting impression on the delicate mind of a child. In order to gain more relevant information, one would have to examine children of a good number of refugees, of various age and family background, shortly after migration and again a few years later, comparing them with a carefully matched control-group of well-settled children. During and after the second world war and already during the unstable political phase before it, with all its refugee movements, very revealing studies have been made on refugee children in Europe. It might have been of equal interest to investigate incidence and forms of emotional disturbance in refugee children in India at and after the time of Partition. Possibly analysis of our adult cases, amongst whom there are patients who became refugees in later childhood or adolescence, may throw some light on the problem.

Migration, of course, has also played a role in the few foreign children whom for statistical purposes we are usually excluding. It may be of interest to consider for a moment their origin and the possible effect any transplantation into a country of different culture and climate may have had on them.

One of the 5 "foreigners" is a Nepali-boy, brought from his village near the Indian border, which means a foreigner only from a formal point of view, but not with regard to any migration or to any vast cultural differences between India and the home-country. Three further children, 2 boys aged $3\frac{1}{2}$ and one girl aged $5\frac{1}{2}$, are American, one girl, aged 9, European. Though all these children were brought for functional disorders, in one combined with an organic defect, none of them can be said to have been exclusively a victim of transplantation, though certain factors of social instability of the parents, in one case also poor health in infancy, possibly connected with unfavourable climatic and nutritional conditions in India, may have played a partial role in producing neurotic deviations.

Conditions somewhat similar to "migration", but exacerbated by the lack of family-contact, may exist for children who are brought up outside the family, e.g. in boarding—schools or with relatives. These cases, however, which mainly occur in the functional group, will be studied in the detailed analysis of each diagnostic group.

6. *Community and Caste*

Next to local origin, we have to characterize the environment from which the children were brought by details about religious community and, amongst the Hindus, caste.

Any such figures, of course, could only be accurately evaluated, when compared with the corresponding proportions in the total population of which the patients form part. As, however, apart from the 48.5 per cent living in Lucknow itself our

little patients came from a very widely scattered area, a comparison of the figures in this respect is almost impossible, all the more, as the corresponding figures for the 1961 Census are not available yet.

For the previous Census, the percentages for the total population were : 84.3 per cent Hindu, 10.5 per cent Muslim, 2.2 per cent Christian, 1.75 per cent Sikh, to mention only the most numerous communities from which practically all our patients were drawn. The yearly total for the patients (children and adults together) at Nur Manzil Psychiatric Center, however, always contained a percentage of Muslims and Christians higher than these figures. This probably reflects the fact that, in Lucknow itself, the share of Muslims is higher than in the total population of India and that the Center, being a mission institution, naturally attracted patients from amongst the Christian group. In these yearly totals, the share of Hindus amounted to something round 70 per cent, that of the Muslims to 15—20 per cent, Christians to about 10 per cent and Sikhs to 2—5 per cent. Compared with this distribution in the total of patients, the percentages amongst the children show a fairly similar pattern, except that the figure for Christians is lower than that amongst the adults. (See Graph II)

What may be of interest, in spite of the impossibility of obtaining "weighed" figures, is to see the differences of distribution according to religious communities within the various diagnostic groups. Even then, however, we have to remember again that any prominence, scarcity or even absence of a particular diagnosis in one or the other community or caste may not reflect the actual incidence or the particular disease, but only the degree of tolerance for a certain defect or distortion, the amount of knowledge about and faith in modern facilities for consultation and treatment, and the willingness and capacity of the parents for spending money, time and interest on a handicapped child.

With all these cautions in mind, let us examine Graph II for any striking peculiarities :

If we take the percentages for the total group of children, which, as already mentioned, differ from the average distribution during the years 1956—1961 amongst the total of patients mainly through the lower figure for Christians, we find the following deviations, which may be significant or at least deserve some reflection :

The share of Hindu children is decidedly smaller than the total average in the group of neurosis and infantilism, greater amongst the oligophrenics, and it even amounts to 100 per cent in the small group of organic children and that of infantile psychosis. While in the organic group this monopoly is without significance, as the proportion of Hindus and Muslims in the whole material is roughly 3.5 : 1, so that there is little chance of the presence of even one Muslim in a group of only 3, one would have reason to expect at least a few cases from communities other than Hindu in the Group of infantile psychosis, which counts 16 children. It will be an interesting task, when

discussing this small group in particular, to examine, whether any factor peculiar to Hindu culture might actually have some correlation with the early occurrence of psychosis in children. The figures for Muslims are above average for both the neurotic and infantile group, while they remain below expectation amongst the psychotic adolescents and, as just mentioned, amount to zero in the group of infantile psychosis. On the other hand, we have several Muslims amongst the neurotic adolescents marked as "borderline cases". This interesting distribution : predominance of the Muslims amongst the "still neurotic" children and adolescents, and lack or scarcity amongst the "already psychotic" ones, again suggests the question, whether there may be any significant differences between Hindu and Muslim culture which, in the former, favours complete disruption when the emotional balance is disturbed, while in the latter, some integrating force still manages to persist. One possibility of course might be that the critical phase, in which psychosis is likely to break out during puberty and adolescence, again due to cultural factors, could occur later amongst Muslims. This, and the previous question of a general difference between the two cultures, can only be decided, once the figures for the adults are compiled and analysed. In a study of certain groups of mental illness based on the case material observed up to June 1960 (HOCH (10)) some interesting differences in the incidence of certain forms of mental illness in the two communities have already been commented on, and the analysis of the whole material in this respect promises some further results worth detailed study.

One further question is, whether the Muslims, amongst whom in-breeding in the form of cousin-and uncle-niece-marriages is quite common, may present a higher incidence of diseases that are determined by heredity. In our material, however the Muslims take the biggest share in the group of neurosis, perhaps the one condition in which heredity definitely plays less of a role than a postnatal environment. Furthermore, our tables on heredity show that the incidence of psychiatric morbidity ("heredity") in relatives reaches its maximum in groups in which Muslims are not prominently represented.

The proportion of Sikhs, Christians and Parsee (only one child), may be too small to draw any valid conclusions. There seems to be a predominance of Sikhs in the functional groups as compared with congenital-organic categories. As to the Christians, the one significant figure may be their relative frequency (10.5 per cent) in the epileptic group, which corresponds to an observation also made amongst our adult patients. (HOCH (11)). This may, however, not be due to an actual greater incidence of convulsive fits amongst Christians, but perhaps rather to the absence of superstitions still current amongst the other religious groups.

At this point the figures may serve to open up some questions ; attempts to answer them, however, can only be undertaken, when the individual diagnostic groups are to be discussed later.

If already a study of the distribution according to communities is somewhat doubtful, as it leads to a splitting up of the figures into units that may be too small to yield any significant result, a further division of the Hindus into the different castes

will accentuate this difficulty even more, particularly if we consider that in 6.7 per cent of all Hindu children the caste was not identified. Furthermore, one has to realize that, nowadays, patterns of living may be determined by other factors, like locality, standard of education, occupational class, more than by the caste itself. We present the figures, but hesitate to draw any conclusions from them. (Graph III) Such factors as a higher rate of education and modern orientation, better financial conditions, greater proportion of town population in one caste or the other, may be more important in determining the number of children brought for consultation than any differences in actual incidence of the various disturbances. In general, one can probably say that, the more drastic the symptom, the more likelihood that patients of scheduled castes will also be brought. This seems to be valid for psychosis and epilepsy, whereas with regard to the oligophrenic group, the small rate of education among low caste people may determine a higher tolerance for mental defects and therefore a small number of consultations.

While amongst the Brahmins and the Kshatryas no sub-divisions were established, though the Kshatryas particularly present no uniform pattern of tradition, we have separated Banyas and Kayasths, who not only stress the distinction themselves, but who, for centuries, have been engaged in very different social and economic functions, the latter approximating in many respects patterns of Muslim culture.

7. *Occupation of Father or Guardian*

If we are to investigate the group of children examined with regard to the family's social status, we are somewhat handicapped, as already in the previous paragraph about caste, by the incompleteness of our data. As many of the children were examined only shortly, either because they were brought without appointment or because the parents, expecting only some magic trick, were unwilling to cooperate in a detailed exploration, not all of the relevant data could be obtained in all of the cases. Information, for instance, about the family-income was only recorded in a few cases and can therefore not be used for any statistics. Even with regard to the father's or guardian's occupation, information is missing in 16 cases, i.e. 7.7 per cent. As with regard to caste, this lack of information concerns mainly the children of the congenital-organic group, who often had to be examined in more of a hurry and where a purely medical interest often displaced sociological considerations. As one will see from Graph VI, the data for the children of the functional group are fairly complete.

While again the tables for the individual categories may not all be very conclusive because of the small figures, it may be worthwhile looking at the graphs representing the distribution in the congenital-organic and functional groups respectively (Graph IVa)

In both these groups, as well as, with small variations, in most of the individual groups (IV b), the two classes of "business" and "service" have provided the largest share of patients. A relative predominance of the class of academic professions and higher functions in service (particularly impressive, if one takes into

account the relative scarcity of such families in the total population, as for instance compared with the business and service class), is found in the functional group and, within this, again particularly in the categories of neurosis and infantile psychosis. While in the latter category, this may actually have some correlation with incidence, as, according to certain authors, infantile autism or psychosis occurs mainly in children of parents with a superior education and a high cultural standard, the large share amongst the neurotics may possibly represent more a phenomenon of tolerance or, in other words of refined attention and sensibility to behaviour disorders of children.

This seems to be borne out by the fact that the percentage of the craft and labour-class in the congenital-organic group is twice as big as in the functional group.

Our former observations on the weak representation of the rural population amongst the congenital-organic cases seems to be confirmed by the occupational distribution : children of farmers and landowners are considerably more frequent amongst the functional cases than amongst the congenital-organic ones. This again poses the problem, whether the phenomenon only reflects a greater tolerance for mental defects, perhaps a superstitious attitude with regard to epileptic fits (one will note that the group of epilepsy contains no child at all from farms !), or whether the fact that most of the few children actually brought from villages and in particular from farms, suffer from functional disorders might be taken to indicate that there is indeed a problem of emotional instability in the rural population, perhaps in connection with the emergence from almost emphatic-symbiotic forms of living into a more conscious and individualistic pattern of life.

8. *Joint and individual family*

Expecting that this problem of emergence, just mentioned at the end of the last paragraph, might find some further elucidation by investigating the number of children growing up in joint families, we tried to work on our data in this respect. One may object that such figures may not have much value unless we know, the proportion of joint and individual families in the total population. Furthermore one has to realize that "joint family" can have a whole range of connotations from actual joint living to a mere common business account. In general, we have only marked as "joint" such families in which physical living conditions were shared by several generations and siblings or cousins of the parents with their offspring.

Again we found that our information was incomplete, particularly, for reasons already explained, in the congenital-organic group. As, for children with functional disorders, greater care was taken to explore the family background, information about the joint or individual status of the family in their group, with exception of a few cases, is fairly accurate. Keeping this inadequacy of the information in mind, one will realize that the remarkable difference between 9.9 per cent joint families in the congenital-organic group and 28.7 per cent in the functional group (Graph V) may only reflect this inequality in completeness of information. When, however, we differentiate

between the oligophrenic and postencephalitic cases that were not complicated by any functional superstructure and those that were combined with neurotic or psychotic features, we shall find that the higher percentages in these latter combined groups (15.8 per cent in oligophrenia with functional admixture against only 4.4 per cent in oligophrenia without functional elements ; 18.2 per cent in postencephalitic disorders with neurotic superstructure against 12.5 per cent in postencephalitic states without neurotisation!) seem to bear out the observation that children with functional disorders are brought more frequently from joint families than those with mere congenital-organic states.

One may ask, whether this reflects a greater tolerance and acceptance for mentally handicapped children in the joint family, where perhaps ambition for the individual child may be less pronounced and responsibility for a non-earning family-member can be shared, or whether the child who grows up in a joint family may, in a quite particular measure, be exposed to strain, when, on one hand still embedded in the secure old order of group-living, he, on the other hand, has to keep pace with the claims of a more individualistic and competitive society outside the family. As this is a question of considerable interest, we shall go into it in more detail, when the neurotic group, in which the proportion of known joint families with 33.3 per cent is highest, is discussed separately. One will then see, that the particular manifestations most frequent in patients brought from joint families seem to confirm the suspicion that these children may be subjected in a quite particular way to difficulties of adjustment in an increasingly individualistic order of society.

At any rate, the results gained from our incomplete figures might serve, if for nothing else, at least as a stimulus to more accurate investigations of this kind on a greater number of children.

9. *Lack of Parents*

In discussions on maladjustment and delinquency amongst children, one often hears the question : "How many of these children were orphans or half-orphans?" and : "How many of them had stepmothers?", in the obvious expectation that a child who is not taken care of by his own parents, in particular his mother, may be more likely to develop in a distorted manner. We have tried to answer this question for the children examined by us in Table VI. If lack of parental care through physical absence of one or both parents is a factor that makes for emotional maladjustment, one would expect that the rate of children who suffered from such lack would be higher in the functional group than in the congenital-organic group. This expectation is indeed justified by our figures :

6.6 per cent of the children in the congenital-organic group, and 13.8 per cent, i.e. more than twice as many, in the functional group, have been deprived of at least one parent, either by death or by separation or divorce. The figures become even

slightly more impressive, if we eliminate from the congenital-organic group the 3 cases of oligophrenia, whose state was complicated by functional trouble (2 neurotic, 1 psychotic). If we add these cases and the combined groups from which they were taken to the functional group, the figures are : 5 per cent children with lack of parents in the congenital-organic group and 13.9 per cent in the functional categories. So, even if we assume that the percentage for our total group, which is 9.6 per cent might perhaps only reflect the frequency of lack of parents in the total population from which the children were drawn (for which we have no figures!), at least this difference between the congenital-organic and functional groups seems to hold up the thesis that absence of one or both parents creates conditions favourable to the development of emotional disorders.

Another objection we have to meet is that, possibly, the functional group may contain more patients of the older age groups, in whom the probability that one or the other parent or both may have died, is greater than amongst younger children. We find indeed that the oldest age-group of 11—16 years amounts to 56.3 per cent in the functional group, while only 45.5 per cent of the congenital-organic cases were of that age. Furthermore, the 3 cases of oligophrenia with functional combinations all belong to this oldest age-group. This renders the higher figures for lack of parents in the functional group somewhat doubtful. Their significance, however, might be proved, if, on examining the age at which these children lost a parent, we should find that the bereavement happened before the age of 11. This is indeed the case with all but 2 cases, both from the group of psychotic adolescents, which, as one will see from Table VI, has the highest rate of children who lost one or both parents. While, thus, this age-factor affects this particular category, which only contains children of the oldest age-group, the total figure for all functional cases still remains high above the rate for the congenital-organic group.

The most frequent type of parental deprivation is represented by death of the mother : 7 cases (5 functional, 1 congenital-organic, 1 combined) with an accumulation of cases in the neurotic group. In 4 of these cases, the deceased mother was replaced by a stepmother. Loss of father seems to be more prominent in the psychotic group 3 children had lost their parents at birth (we do not know, whether through death or due to illegitimate birth) ; 2 of them were brought up in children's homes, while one boy was adopted by a woman who lived separately from her husband.

In 3 cases, the real parents lived separately or divorced. Considering that the one case in the oligophrenic group is one combined with neurosis, we get a slightly higher percentage for the functional group than for the congenital-organic one.

A rather strange fact, which possibly may have its significance, is that 3 of the 17 children in the group of infantile psychosis (including the one Nepali boy) came from polygamous marriages, while in none of the other families two wives were living simultaneously.

Other extraordinary features of the parents' marriage, such as love-marriage, (two cases) and intercaste-marriage (two cases), are only to be found in the functional group. As they reflect a modern attitude, one cannot necessarily conclude that these forms of marriage may lead to a particular instability in the family atmosphere, but it may be that parents who are so advanced to disregard tradition with respect to choice of a marriage-partner, may also be more emancipated in seeking help for their children. These, however, are detailed questions which can only be answered in the individual case.

A relative deprivation from parental care can also be given through absence from home, either of one of the parents or the child himself. With the prevailing system of frequent transfers and touring jobs in service, many children have to miss their fathers often for long period. Details about situations of this kind, wherever relevant, will be given in the individual diagnostic groups.

Physical presence of the mother may amount to something like absence or even worse, when the mother's interest is diverted away from the child to work outside the home or to higher studies. The 8 working mothers and the 3 running after higher education, were nearly all to be found in the functional group. The theory, maintained by some authors, that infantile psychosis occurs mainly in children of parents with high intellectual and cultural standards and ambitions, seems to be supported by the fact that all 3 studying mothers belong to children of this group ! We shall have occasion to consider this peculiarity more closely, when dealing with this group in detail.

10. *Heredity*

While thus, according to the data given in the last chapter, we have reason to assume that absence of parents through death, separation or preoccupation with work is a factor that contributes to functional psychiatric disorders in children, one will expect that, where heredity is concerned, the figures might weigh more heavily on the congenital-organic side. One examining the first horizontal column of Table VII, giving the total of cases in which some psychiatric illness had been signalled amongst the relatives, we find that the figures are not justifying this expectation. Though the rate with 51.5 per cent is high in the oligophrenic group, we find that it is still higher in the categories of psychotic adolescents and children, while the neurotic group still shows a rate considerably higher than the 3 remaining congenital-organic groups. If, however, we break down these totals into figures for congenital and organic conditions amongst the relatives on one hand (oligophrenia, epilepsy, syphilis and other organic affections of the central nervous system) and functional psychiatric disorders on the other hand (neurosis and psychosomatic affections, psychosis, extreme character features and addiction to alcohol), the figures may be more revealing. In examining these broken down figures for individual diagnostic categories, and the organic and functional division of heredity, we will have to realize that they do not add up to the total number of children in the group, as one and the same case may have several relatives with different disturbances. In the column of "total cases", each child, no matter how

many relatives with psychiatric disorders were indicated, is counted only once. The same case may, however, figure in several of the other columns, with the one restriction that any one form of disease, even if occurring in several of the relatives, was only counted once in the corresponding group, thus marking the occurrence of a hereditary "factor" as such and not the frequency or intensity of its presence.

With this technical detail in mind, we can now turn to the figures which attempt to present a more specific heredity, and we will understand that it would not do to relate them, e.g. in the form of percentages, to the total number of children in each group. The only percentages we have calculated in this way, are those for "specific heredity" in each column, i.e. the number of relatives found to suffer from the same type of psychiatric disorder for which the child in question was registered. The method we have chosen to show, whether for a particular diagnostic group organic-congenital affections or functional disturbances are more frequent amongst the relatives, is to equal the former to one and then to calculate the proportion in which the latter stand to this basic unit. We thus find an almost exclusive occurrence of functional "heredity" in the group of psychotic adolescents and a marked predominance of the same in the group of neurosis and infantile psychosis, while in the oligophrenic, epileptic and organic groups, as expected, functional disturbances amongst the relatives are outweighed by the organic and congenital affections, amongst them syphilis, with a quite considerable rate. Not fitting into this pattern, we find the group of postencephalitic states and infantilism. As, however, encephalitis is an acquired illness, this result is not so unexpected. The figures for infantilism, on the other hand, are quite inconclusive, as all 3 psychiatric affections indicated were found amongst the relatives of one single child, while for the 5 other children the column for heredity remained blank.

We then find that the group most heavily loaded with functional disturbances amongst relatives is that of the psychotic adolescents, the one with the greatest proportion of organic and congenital disorders amongst the relatives the oligophrenic group. The even higher figure for the organic group has to be eliminated, as the group is too small, and again all forms of heredity found apply to one child only. Thus the result is fairly according to expectation, with the exception that the low over-all rate of heredity and the relatively small predominance of organic-congenital conditions over the functional in the epileptic group (from which symptomatic cases have been eliminated as far as possible), is somewhat surprising. The reticence we found with regard to signalling epileptic phenomena even in the patients themselves, may, however, also have applied to relatives who had fits. Furthermore, this apparent lack of "heredity" may be somewhat explained, when we consider the next table, dealing with early mortality amongst the siblings of the patients.

To an observer coming from the West, the great number of siblings who had died either soon after birth or in infancy and early childhood, and even the number of abortions in our patients' families was rather striking. It is of course known that the infant mortality rate with 100-120 is still much higher in India than in Western countries,

and that infectious diseases still take a great toll from amongst children. Even then, one is rather shocked to find families, as in one of our cases, in which out of 17 children born only one is surviving ! The matter was therefore investigated and the results tabulated (Table IX) in connection with heredity. Table IX shows that 37.5 per cent of all children came from families in whom at least one of the siblings had died in infancy for childhood. This average of the total group is surpassed by the groups of adolescent and infantile psychosis, epilepsy and oligophrenia. It is interesting to note that, with the exception of epilepsy, these are again the groups that showed the highest rate of psychiatric morbidity amongst the relatives. Neurosis, which would come next in the scale of frequency of "psychiatric heredity", takes a less significant place, below the total average, where sibling mortality is concerned, epilepsy and postencephalitic states taking the higher ranks. With regard to the inordinately high figure of sibling mortality in the group of adolescent psychosis, we again have to remind ourselves that this group only contains children aged 13—16 years. The time-span, during which siblings could have died, is therefore longer than in younger children. Also, particularly in those families in whom the patient is one of the youngest children, the reduction of infant mortality through the advances in medical and preventive health services during recent years may have had less of a chance of taking effect than in "younger" families. This reflection is not valid for the group of infantile psychosis, in which all children are below the age of 12, and for the epileptic group, in which the number of children below the age of 11 is slightly bigger than of those above 11.

One possibility we have to consider, is of course that a mentally deficient or organically damaged child from a family in which few or even no other children have survived, is more likely to be brought for consultation than one who has got plenty of healthy siblings. On the other hand, the excessive care and perhaps possessiveness and over-anxiousness, which parents may concentrate on one or a few surviving children, may be likely to lead to functional disorders in handicapped as well as congenitally healthy children. These, however, are fine distinctions which can only be recognized in individual cases.

In a later table, presenting the number of children in each family (at bottom of Graph VI), we find a row of figures which further accentuates the correlation between heredity and sibling mortality : if we count not only the number of families in which at least one child has died, but the number of children out of the total of siblings who had died, we find a figure of 18.8 per cent for the total of children. Epilepsy, with 25 per cent, i.e. 1/4 of all children born in the patients' families, tops the list, oligophrenia coming second with 21.8 per cent and infantile psychoses third with 19 per cent, while the group of adolescent psychosis, in which apparently no great number of children died in any of the families, falls back into fifth rank from its very prominent position on the table about the number of families in which children had died.

Let us now remember that the connection in which we introduced this inquiry on sibling mortality, was the low rate of "psychiatric heredity" in the group of epilepsy, in which now we find the highest rate of sibling mortality. The question one may then

ask is, whether the same factors of genetic deterioration may possibly express themselves at one time as a lack of vitality that does not allow survival beyond an early age, while in other cases life continues, but in an impaired form? In other words can we perhaps assume that, in the group of epileptics, the rate for "psychiatric heredity" is so small, against all expectations, because, not only amongst the siblings, of whom more than 25 per cent died (the 25 per cent is counted from a figure including the patients themselves!), but also amongst other relatives, those in whom the pathological genetic factor may have been present, were so poorly endowed with vital forces that they never reached the age at which any defect could have become manifest? Another argument is that perhaps parents who are so careless, inexperienced and unconsciously rejecting that they cannot keep all of their children alive, might also be likely to neglect the surviving children in a way that could be harmful to their mental and emotional development. This might be valid, as far as the groups of functional and acquired diseases are concerned, i.e. in particular for the groups of postencephalitic state and infantile psychosis, in which the figures for sibling mortality are high. But this argument cannot possibly explain the high figures in the groups of oligophrenia and epilepsy. It is far more likely that, in these two groups, the same factor of hereditary deterioration may in one case, —oligophrenia—, have determined a high rate of manifest heredity of organic-congenital type, and a high rate of sibling mortality, while for the epileptic group the high sibling mortality may only be part of a general inability to survive in these families, in other words something like a "letal factor", which absorbs some of the potential manifestations of hereditary conditions.

After all these rather complicated and perhaps all too hypothetical discussions, we can say that, either the table on psychiatric heredity or the tables on sibling mortality, or both together, justify the text-book expectation that hereditary factors are most likely to be at work in oligophrenia, epilepsy and psychosis.

Apart from this satisfactory coincidence of our statistical results with theoretical expectation, we have, however, to explain the high rate of "heredity", though not of sibling mortality, in the neurotic group.

Of course, even text-books admit that neurosis is not only a result of environmental influences, but that a certain constitutional, possibly hereditary weakness of the central nervous system may favour its development. Even then, there remains the problem of the proportion between constitutional and environmental factors in each individual case.

We now have to draw attention to the fact, which may have been overlooked or perhaps noted with some puzzlement, that, in the past few paragraphs, we at times have very cautiously put the term "heredity" between brackets, particularly when it stood for the occurrence of any of the disturbances of functional type amongst the patients' relatives. One may indeed ask, whether the mere existence of emotionally disturbed family-members may necessarily mean that their lack of balance has found a biological substratum in the germinal cells transmitted to the child in question, or

whether they may not much rather have exercised an unfavourable postnatal influence on the child's emotional development or whether, a third possibility, both child and relatives may have been subjected to the same unfavourable environmental influences. Some authors nowadays maintain that, even in schizophrenic/psychosis, biological heredity may be less important than the influence of certain family patterns and attitudes determined by the presence of emotional distortions in family-members. As any such influence would be most likely to emanate from the parents, we have assembled, in a further table (Table VIII), all these cases in which one of the parents or both suffered from a psychiatrically recognizable deviation. The table on heredity already given (Table VII), contains data about any family member known to the child's parents to have presented some mental trouble: grand-parents, uncles and aunts, cousins, siblings, which means partly people with whom the child may never have been in contact. Furthermore, information may not have been very complete, as conditions like epilepsy, oligophrenia, and in particular also the less severe functional troubles, may have passed unidentified in the older generations, who grew up in a more tolerant and less medically oriented social climate.

Our investigations of parental psychiatric morbidity do not only rely on the parents' accounts of themselves and each other, but also on our own observations of their behaviour, which in many cases revealed obvious neurotic features. Three of the mothers and 4 of the fathers were particularly well known to us, as they themselves had been treated at the Center. This table now is less likely to indicate any biological heredity in the strict sense of transmission of pathological genes, but will rather give a measure for the emotionally unsettling influence in the closest family-environment. One would reasonably expect that it should demonstrate a prevalence of parental psychiatric morbidity, particularly of the functional type, in children of the functional groups.

As a child's contact, particularly in the impressionable years of infancy and early childhood, is much closer with the mother, and any maternal emotional disturbance therefore more likely to have an effect, we have set up separate columns for fathers and mothers, but added a column of all cases in whom any parental morbidity (either father or mother or both) was noted.

According to this last mentioned column, the figure for parental psychiatric morbidity is highest for psychotic adolescents, with the group of infantile psychosis as a close runner-up. Next comes the neurotic group. All the figures of the congenital-organic group are lower: the group of infantilism again, as we already noted previously, again deviates from the pattern of the rest of the functional group.

The relatively high figure for oligophrenics is explained by the considerable number of syphilitic fathers and mothers. Parental syphilis can lead to congenital though not always hereditary, damage of the central nervous system, which manifests itself in mental deficiency, possibly convulsions and other disturbances. One will also note that, in contrast to all other groups, except the postencephalitic one, the congenital-organic affections of both father and mother predominate over functionally disturbed parents in the oligophrenic group.

In the functional groups, very few of the parents suffered from any non-functional trouble. One will, however, note that 3 of the children in the infantile psychotic group had mothers whom we have placed into the category of oligophrenia. This diagnosis was partly made on the fathers' indication that the mothers were "mentally dull", partly on the basis of our own impressions. As we had no occasion of examining these mothers thoroughly, we cannot exclude that the one or the other may have been emotionally inhibited rather than congenitally defective. At any rate, they all gave us the impression that they were not able to provide the child with sufficient intellectual and emotional stimulus for a normal development.

One will see that both paternal and maternal morbidity reach their highest figures in the two psychotic groups, the maternal rate being significantly higher than the paternal one in both. While the next ranks for paternal morbidity are occupied by oligophrenia and epilepsy, disturbances in mothers are more frequent in the neurotic group than in any of the congenital-organic groups. The figures for functional disturbances in parents are higher throughout the functional group than in any of the congenital-organic groups, with the exception of infantilism, which group, as we already have pointed out before, in many respects does not follow the pattern of the functional group. Furthermore, quite a few of the parents with functional trouble in the congenital-organic groups are those of children who presented a functional super structure.

These figures render it highly probable that much of what at first sight imposed as heredity in a biological sense, may only have been a "pseudo-heredity", not transmitted through genes and chromosomes, but through the close environmental contact between parents, particularly mothers, and their small children.

We have not established any separate statistics for the incidence of psychiatric disorders in the siblings of our patients. There are, however, 5 cases in which two or even 3 children of the same family were examined by us. We shall mention them in the detailed study of their respective diagnostic categories.

11. *Number of siblings and position in the sibling row*

In trying to characterize the family background which had helped to shape and possibly to distort the children in our case-material, our next task is to investigate what place they take amongst their siblings.

Not only amongst the children, but also amongst the adults who came under our observation, there seemed to be, on a mere estimate, a remarkable number who had been either born or left by death of other siblings, in a prominent position, in particular that of the eldest or youngest child. One knows well that any situation in which a child gains a certain uniqueness, perhaps a monopoly of attention and affection, can cause just as much harm to his emotional development as a situation of neglect and ejection.

Here in India, it is particularly the role of the eldest son which can weigh heavily on a child. Bassa (6), in his recent study, also comes to the conclusion that "male eldest children seem to be particularly prone to psychological disturbances, especially scholastic difficulties." The boy may be pampered, admired, respected for nothing else but his position, in a manner that never teaches him to bear any frustration and resistance, while at the same time, as he grows older, the expectations of the whole family are centred on him. When he reaches an age at which he begins to realize his responsibilities, the fact that his future life is not his own, but to be devoted to the prosperity, security and general welfare of the family, the selfishness and love of comfort bred by the early pampering may not have prepared him in any way to face this task of selfless devotion and of hard work with little personal gain. He may continue to expect from a wider society the support, special appreciation and respect he enjoyed through his position in the family, without realizing that now it is time to show his own intrinsic worth and to merit a position instead of simply claiming it as his birthright.

Another problematic position may also be that of the eldest daughter, quite particularly if she has to give up her privileged place as the first child at birth of an even more cherished brother. Parents seldom seem to realize that their unrestrained pouring out of all their store of affection, concern, pride and ambition on one single child, who happens to be the first one, springs in no way from real love and concern from the child but reflects a rather selfcentred attitude and a quite immature lack of self-control and foresight.

On the other hand, the youngest child may also fall a victim to the possessive love of his parents, particularly the mother, as he may gradually become the only one who is still within reach of overanxious care and affectionate effusions, while the elder siblings may already have ventured out into a wider world. Similar dangers may beset the development of an only born or only surviving child.

We shall have to say more about such often subtle shadings in parents' attitudes in a special chapter. These few instances of extreme attitudes were only mentioned in order to show that a search for the incidence of special positions in the sibling row amongst our young patients may be of interest, particularly for the group of functional disturbances.

One may now perhaps think that, by a mere counting of all children who occupy any special position and by calculating their percentage with regard to the total group one might get a "fair estimate" of their importance. For instance, if one finds that, in the neurotic group, 34 out of 54 children, i.e. 62.9 per cent are eldest ones, either absolutely or of their sex, youngest ones or only ones, one might exclaim: "You see, more than half of the children, the majority, have been exposed to special attention!" This, however, would betray very shortsighted reasoning. We can only know, whether the incidence of special positions in a patient group is significantly higher than one could normally expect, if we can correlate the percentage of these specially placed children in the patient group to the maximum number of special positions possible

amongst all siblings of these children. In calculating this correlation, one again risks to be misled by a shortcut : one might simply reason that, in one family, there can only be one eldest or only child, one youngest, and possibly, if there are girls and boys in the family, in addition to the eldest child, an eldest boy or girl. So the rate of maximum possible special positions would be represented by the number of children in all families added up, divided by the number of families and multiplied by 3. This procedure, already fairly lengthy and complicated, however, still does not take account of the fact that, in families with 2 children or one child only, the number of special positions is reduced to 2 or 1 absolutely, but relatively, as already in families with 3 children, increased to 100 per cent. Furthermore, we have to take account, not only of children born in a special position, but also those left as the eldest, youngest or only ones by the death of siblings. To get accurately weighed figures, is therefore a quite tedious undertaking. If we have ventured on it all the same, it is because our spontaneous impression, that such special positions were playing a role in our material was too strong just to be discarded or to be maintained as a mere hypothesis without solid proof.

In the process of calculating the weighed figures, we gained, as a kind of by-product, a graph representing the number of children born and surviving in each family, which has its own interest and which therefore one might pause to consider for a while. (Graph VI).

The figures given at the bottom of the graph have already served to provide us with the percentage of children who had died in infancy or childhood in the families to whom our little patients belong. One will remember that, in the group of epilepsy, the rate, with 25 per cent, was particularly high.

The figures have also allowed us to calculate the average number of children born and surviving per family. For the whole group, this is 5,2 born and 4, 2 surviving, which would mean that approximately one out of every 5 children died. The highest average of children born is reached by the group of psychotic adolescents with 7,3, the lowest by the group of infantilism with 2, 8 children per family. Again, however, one will have to realize that, in the group of psychotic adolescents, the average age of the children is higher and therefore the chance that they come from already complete families, even if the patients should be amongst the eldest children, greater than for a group in which the children are practically all of a low age, as it is the case for the group of infantilism. Still, even so, it may be rather remarkable that, in the families of the psychotic adolescents, the number of children is neither very high nor very low, in particular that we find no families with less than 3 children, while families with one and two children only occur in all the other groups. This average of 7,3 children per family is therefore fairly representative, with little deviation towards either side.

As, contrary to this, the distribution in some of the other groups is so scattered that any average is only a very artificial product of wide deviations, comparison with any figures for the total population, in the expectation of gaining some measure, whether the families in our groups are particularly rich or poor in children, can only convey

little meaning. Still, it may be interesting to add some information gleaned from a newspaper article (CHANDRA and PRASAD (12)). According to it, the average number of children in India (presumably in completed families) is 7.3 in poor families and 4 in rich. The only figures in our material that remain below these averages, are the low rates for the group of infantilism and infantile autism. As we have already pointed out, families of small children are less likely to have reached their full size than families of elder children. It is, however, possible that the prevalence of socially and economically better placed families in this group (see Graphs III and IV) may also be reflected in this small number of children per family.

One fact that might give food for reflection, is the relatively high number of families with many children in the oligophrenic group. As we have seen, (Tables VII—IX), this group has a particularly high rate of psychiatric morbidity amongst the relatives and also of sibling mortality. Any demographic planning and propaganda,—nowadays an important concern here in India!—has to face the problem that the very people who are accessible to arguments and conscientious in any kind of control, are usually also the ones who, even without being encouraged or urged, would be likely to keep their families small. On the other hand, the very people, the careless, ignorant and uneducated, who go on producing children without any sense of responsibility and foresight, are also the ones most difficult to reach by any explanations and methods of birth control. At the same time, if any genetic deterioration is present in either of the parents, the ignorant and careless will not only produce many children, but their progeny may also manifest or at least carry on the morbid strain. One may argue that people affected by the most severe forms of mental deficiency may never be in a situation to get married. Even if this is true, and we have seen families here in India, who, for the sake of “dharma”, or possibly just to get rid of a burdensome daughter, undertook everything to get even a seriously handicapped child married!—, this would help little to prevent the propagation of morbid heredity. The forms of mental deficiency most likely to be hereditary, are the milder ones. Such people, however, particularly under the system of arranged marriages, are quite likely to be supplied with a marriage partner and to produce children without discretion.

In some of the Western countries, legislation provides possibilities for objecting to an unsuitable match and for declaring a person as unfit for marriage. Thorough psychiatric investigation has to prove that one or the other of the prospective partners or both are incapable of grasping and appreciating the meaning of marriage and of accomplishing the tasks of providing for a family and bringing up children in a responsible manner. In some cases, marriage may be allowed, but only after sterilisation of at least one of the partners.

As up to now, here in India, the joint family provided a certain security even for married couples who could not realize their responsibilities, there may have been no reason to think of restrictions of this kind, which of course would have offended very severely against the religious concepts of marriage amongst the Hindus. If,

however, a social welfare state is to provide more and more of a frame of security for a population mostly split up into individual families, if, furthermore, individual choice should gradually replace the system of arranged marriages, one may have to think of safeguards of this kind.

Though in some of the case-histories of the children examined, notes were made about the parents' use of contraceptive methods, the material is not sufficiently complete to justify any investigation. The few cases in which the mother had attempted abortion during pregnancy with the unwanted child examined by us or during a subsequent pregnancy, and those in which overcautious and probably rather selfish parents were determined right from the start to limit their families to two children or even only one child, will be mentioned in the detailed study of the individual groups.

As a question of principle, one may, however, ask already now, in what way parental attitude may possibly be affected, once the parents have it in their hands to regulate the size of their families without depriving themselves from satisfying their desires. Will the extensive use of family planning lead us back to the ideals proclaimed in traditional literature on Brahmacharya, which advises parents to save their reproductive energies for one or at most two children who will grow up strong and healthy and with the full love of their parents? Or will the same outward result, reached not by inner self-restraint, but by outward appliances or even irreversible operations, that allow full play to desire, perhaps differ in spirit? Will the attitude of parents who, instead of mastering their creative energies, have fooled and cheated them for the sake of their own pleasure and convenience not be marked by selfishness, over-anxiousness, perhaps even guilt-feelings, and will the concentration of all their ambitions on one or very few offsprings not weigh as a heavy burden on the free development of these children? Some of our case-histories may possibly contribute individual observations in this respect. It may be the task of future generations to evaluate not only the obvious benefits, but also any possible unfavourable changes in parental attitude brought about by the present wave of propaganda for family-planning.

To come back to our initial quest, the possible predominance of "special positions" in the sibling-row amongst the children brought for consultation, Graph VI and Table X give us the material for gaining weighed figures. The maximum of possible special positions in any category is calculated by assuming 3 possible special positions per family with 3 and more children, and 2 and 1 special positions respectively for families with less than 3 children. One will realize that the figure thus obtained may be rather too high, as it neglects the fact that in a family of all boys or all girls no position of eldest daughter or eldest son occurs in addition to that of the eldest child, or that an eldest boy or girl may at the same time be the youngest child. Detailed study of the structure of all families might have eliminated this inaccuracy. As, however, we are only out to make sure that any seemingly high actual figure of special positions amongst our patients is greater than a maximum possibly to be expected, this is not necessary. Leaving the figure of possible special positions in this relatively crude state, will only

increase the certainty that any actual figure higher than it represents indeed an extraordinary accumulation of special positions.

The next step is to transform the figures for possible special positions into percentages of the total number of children in all families of the respective groups. For this, only those families were counted, for which the number of children born and surviving were known; those for whom information was missing or doubtful, were left away for all calculations. In parallel fashion, the actual number of special positions in each of the diagnostic groups is converted into a percentage of all children in the group. We can then compare the two percentage figures and state, whether the actual rate is higher than that to be expected, if all children in the patients' families had been exposed to an equal risk of getting ill.

The same procedure is repeated with regard to the children surviving in each family, this time including amongst the special positions the eldest child surviving, eldest daughter or son surviving, only and youngest child surviving. One will realize that the sum of possible special positions will change only as far as death of any children has reduced a family from a size at or above 3 to a size below 3 children. The percentage, however, will be increased, as it now relates to a smaller total number of siblings. The actual special positions amongst our patients are in some groups considerably increased by those children who become eldest, youngest or only ones through death of siblings. The increase in actual special positions, however, has to be matched with an increased percentage of possible special positions, so that the result need not always be a differential figure greater than that already calculated for the children born. For our purpose, i.e. the study of the possible emotional effect of a unique rank amongst the siblings, the figures for the surviving children are more essential than those for the children born, as they reflect the actual situation at the time of consultation. An eldest, only or youngest surviving child may even be more exposed to harmful parental attitude than a child born in that particular position, because the parents' grief, frustration, anxiety and possessiveness may be concentrated on him or her in a quite particular measure so as to compensate for the loss of other children. We therefore are going to base our analysis on the figures gained for "surviving siblings" only.

Table XI, in which the figures calculated according to the explanations given above, are assembled, seems to reward the efforts taken to establish it. For the total group of children, we find that the rate of actual special positions exceeds the maximum to be expected, if all children had had equal chances of being or becoming psychiatrically ill, by 5.7 per cent, i.e. about 1/11 of the "possible" figure of 64.5 per cent. This difference, however, is not very relevant, as it includes the data for all groups, while our curiosity in this respect is actually mainly directed towards children with emotional disorders. In the functional group, we find that the psychotic adolescents rate highest with an excess of actual over possible special positions as big as 12.9 per cent or more than 1/4 of the figures for possible special positions. The neurotic group, with an excess of 7.0 per cent, approximately 1/8 more than the possible rate, also comes up

to our expectations. The group of infantilism with—20 per cent and that of infantile psychosis with—9.7 per cent, however, remain far behind the possible rate. One has, however, to consider that, in these 2 groups, small and smallest families predominate, so that the maximum possible figures for special positions (column 2 of Table XI) are highest of all categories. Therefore, though 4 out of the 6 infantile children and 11 out of 16 infantile psychotic children occupy special positions, this relatively big number still does not go far enough to reach the high percentage of possible special positions in the small families (5 children per family at most for infantilism and 6 surviving ones at most in infantile psychosis).

Rather surprisingly, we find that even in the congenital-organic groups, with exception of the organic one in which the "actuals" come exactly up to the possible rate, special positions are more frequent than one would be entitled to expect, if the risks of illness were the same for each child. As this result was somewhat puzzling, we took the trouble of eliminating all cases combined with functional superstructures, as they might possibly have vitiated the result. This operation was worthwhile: In the group of oligophrenia combined with neurosis or psychosis, we now find an excess rate of 18.3 per cent, almost $\frac{1}{3}$ beyond the possible maximum, as compared with 5.8 per cent for the total group of oligophrenics. In the postencephalitic group, the very negligible 0.8 per cent excess is increased to a respectable 12.9 per cent, i.e. $\frac{1}{5}$ beyond the possible maximum. Without calculating the rate for the "pure" oligophrenic and postencephalitic cases, we can say that, in order to reduce the high rate of the combined group to the small figure of the total group, the differentials must have been near or below zero.

The group of epileptics which, in spite of a reduction of most families to a small number of children through frequent deaths, still shows a rate of actual special positions exceeding the possible ones by 15.5 per cent, about $\frac{1}{5}$ beyond the maximum possible, keeps a significant excess rate of 11.5 per cent, even if we eliminate the cases combined with neurosis. The excess rate in this small combined group, however, amounts to 33.3 per cent, as in fact all of the 6 children in whom epilepsy is combined with neurosis, occupy special positions in their families, either by birth or by survival.

These figures for the congenital-organic group and its functional complications can be seen from 2 points of view: On one hand, the children of the combined categories can serve as a kind of control-group, which quite generally confirms our supposition that children in special positions are more likely to develop functional disturbances than their less conspicuously placed siblings. On the other hand, one might see, in these figures, a particular proof for the fact that organically and congenitally handicapped children have more of a chance of growing up harmoniously, if they occupy an indifferent position in their families than if they are exposed to the hopes and expectations usually fixed on an eldest child or the pampering and possessive care devoted to an only surviving or youngest child. In other words: the child growing up in an indifferent position in his family, unless of course he may be neglected amongst too many

siblings, has more chance of just becoming "himself" or "herself", while the child in a special position, no matter whether physically healthy or not, risks to become moulded by a ready-made role, which either may leave him no change for developing and trusting his individual potential or, on the contrary, may provoke him into rebellion and forceful assertion or withdrawal, so as to save what he really is from what the family wants to make of him.

One may ask, which particular one of the special positions investigated is most frequent and in excess of expectation. Calculation of this is relatively easy: If all chances of falling ill are supposed to be equal in any position, the rate at which any one position occurs should not be higher than the number of patients divided by the average number of children per family of the particular diagnostic groups. We then find that the position of the first and in some cases only child occurs in excess of expectation in the group of oligophrenia, postencephalitic states, epilepsy (all including the functional complications), neurosis and, to a slight extent only, in the group of infantilism and adolescent psychosis. The rate for all special positions is swelled amongst the psychotic adolescents by the number of eldest daughters who are not at the same time first-born in the family. For the total of children, the actual rate for eldest and only children surviving exceeds the expected rate by almost exactly 50 per cent. The greatest excess rates are contributed by the groups of neurotics and postencephalitics, in both almost twice the expected figure, i.e. 100 per cent excess, while in the oligophrenic group the excess rate is a little less than 50 per cent. Rates for the youngest children do not exceed the expected rate in any of the categories.

It will be an interesting, though onerous task to carry out a similar investigation amongst the adult patients, amongst whom, as yet unconfirmed by any exact calculation, the rate of eldest sons seems to be remarkably high in certain diagnostic categories.

As to the children, we shall have occasion to illustrate the somewhat dry and colourless figures by presenting individual examples later. At the same time, the study of separate diagnostic groups will allow us to investigate those cases in which "sibling rivalry" played a significant role.

12. *Age of the Mother at the Child's Birth*

The high rate of sibling mortality and the considerable predominance of special positions in the epileptic group made us wonder, whether these peculiarities might perhaps have something to do with the age of the mother at birth of the child. One can imagine that a very young mother may not only be biologically too immature to produce healthy children, but also psychologically unprepared to care for them. There are furthermore some theories that maintain that certain forms of mental deficiency, in particular Mongoloid Idiocy (see later in chapter of oligophrenia), occur more frequently in children of old mothers. The already quoted article by CHANDRA and PRASAD (12) states the problem as follows: "The age of the mother affects child's health. Congenital deformities are more common in children born to mothers before the age of 19 years and after 40 years. Abortions, miscarriages and still-births are also more common in such mothers."

As, in comparison with Western countries, the period of procreation is often stretched over a bigger area of a woman's life here in India, an investigation of the mother's age at the birth of the children examined, promised some interesting results. Any figures given, of course will only have a limited value, as for instance in the epileptic group with its high sibling mortality, an eldest or only surviving child may have been born at a time, when the mother already had passed the age of 20, but after a whole series of abortions, still-births and deliveries of children unfit for survival beyond infancy. So, our figures cannot serve to prove the statement put forth in CHANDRA and PRASAD's article (12) and in many textbooks in a general way, but only to a very limited extent for the cases of our material.

A further flaw is that we have no figures about the average distribution of mother's ages at birth of children for the total population. The question would further be, whether such figures, if to be procured, should be taken only for the birth of a first child or for the subsequent children too. So, any marked representation in the lowest and highest age-classes in our total group may only reflect a state of things customary here in India, but noted with special interest by the foreign observer. Some relevance, however, may be attributed to differences between the various diagnostic groups in incidence of mothers of the extreme age-groups.

After this chapter had already been completed, we received some data through kindness of Dr. (Miss) ENGINEER, Head of the Department of Obstetrics and Gynaecology of Lucknow Medical College, referring to the women who come for delivery at Queen Mary's Hospital. One can probably assume without going far wrong, that mothers who seek admission at a hospital for delivery will belong to fairly similar social strata as those who would bring mentally and emotionally disturbed children to a psychiatric clinic in the same city. Figures for this department of Lucknow Medical College, of which we shall have occasion to quote more later, may therefore be more reliable for comparison with our material than any figures for the total population might be. Possibly the "population" of the obstetric wards of Queen Mary's Hospital might, if anything, be a bit less sophisticated than the patients of our private Psychiatric Center.

Dr. ENGINEER indicates the percentage of mothers who give birth to children before the age of 20 years as 15.8 per cent, that of mothers who give birth to children after the age of 35 with 7.3 per cent.

It may be interesting to compare these figures with those of a Swiss maternity clinic in a city about half the size of Lucknow, the University Clinic for Obstetrics and Gynaecology at Basel (Director Prof. KOLLER), which gives the number of women coming for delivery before the age of 20 as about 3.0 per cent, of those still giving birth to children after the age of 35 as little over 2 per cent.

Table XII shows that, once again, our material was incomplete. The percentage of mothers in the lowest (below 16 and between 16 and 20 years) and the highest (35-40 and beyond 40) age-brackets, to be referred to as "young" and "old" mothers, is

calculated with regard to those cases in which the mother's age was known. Accordingly, we find, for the total of all children, a rate of 21.7 per cent for "young" mothers and of 6.3 per cent for "old" mothers, i.e. our total group only goes beyond Dr. ENGINEER's figure for young mothers, but remains behind her rate, where old mothers are concerned. Both figures, however, are still considerably higher than those for the Swiss maternity clinic.

This average rate for young mothers is exceeded considerably by the epileptic group, in which 50 per cent of the mothers were aged below 20, a state of things which rather confirms the suspicion which originally had led us to undertake this particular investigation. As, at the same time, in the epileptic group, eldest and only children, particularly those placed into these positions by death of siblings, exceed the expected rate by almost 100 per cent, one may be justified in assuming that very young mothers are more likely to produce children with insufficient capacity for survival or with a labile, hyperexcitable nervous system that might respond to stress with epileptic manifestations. As this group (see Graph IV) does not contain a particularly great percentage of children from the craft and labour class and none at all from farms, the argument that perhaps the customs of earlier marriage in these social strata might tell on the figure for young mothers, can be discarded.

The figure next in size, though with a considerable distance, is that for oligophrenic children, with 21.4 per cent of mothers aged below 20. As the excess rate of eldest children in this group is less significant than in the epileptic group, the chances of finding very young mothers is naturally smaller. Next in rank come the groups of neurosis and infantilism with almost equal figures of 20.9 per cent and 20 per cent.

While amongst the congenital-organic groups the presence of young mothers may have its significance from a point of view of biological immaturity, marked representation of young mothers in groups of the functional type may make us rather expect psychological immaturity and helplessness as a factor contributing to the child's distorted development. Individual examples will have to show us, how far an assumption of this kind is really justified.

The psychological immaturity of a mother may not have caused much harm to a child, as long as both, mother and child, were sheltered within a joint family. Nowadays, however, a relatively young and inexperienced woman may have to cope with duties and problems of motherhood all on her own, perhaps even without the constant support of a husband, who may be on tour or otherwise preoccupied by his work.

With regard to old mothers, aged above 35, only the group of psychotic adolescents, with 20 per cent, shows a rate considerably exceeding not only our average, but also that indicated by Dr. ENGINEER. The high rate of the small organic group, which is due to one case only, is not conclusive. The significance of the figure for the psychotic group can probably only be understood in correlation with other factors and will be examined in the detailed study of this group.

The oligophrenic group shows a rate of 5.3 per cent for old mothers. Only one of the 4 children suffering from Mongoloid Idiocy contributed to this group with a mother aged above 40.

13. *Complications of Pregnancy and Delivery*

Complications during pregnancy and delivery with an appreciable effect on the child's physical fitness are to be expected mainly in the congenital-organic group, while in the functional group such factors as "shock", depression or other psychological disturbances of the mother during pregnancy, though they may not directly have caused any harm to the embryo, as some popular superstitions suppose, may at least have been signals of unbalanced maternal attitudes, which may also have exercised their effect after the child's birth.

On inspecting Table XIII, we find indeed that physical disturbances of pregnancy, like imminent abortion, severe physical illness or accident of the mother, were fairly frequent in the group of oligophrenics. This figure is exceeded by that of the group of infantilism, where, however, the percentage of 16.6 per cent is due to one single case only. The rate is furthermore high in the postencephalitic group. We have mentioned earlier, and shall have occasion later to come back to the fact that this group includes some children in whom the damage to the central nervous system may not have been entirely postnatal, but at least partly due to some intrauterine influence, which may have prepared the ground for a later infection.

It may be of interest to note, in this connection, that the one Anglo-Indian child classified in the small group of organic cases (Not mentioned in the statistics, as only Indian children are included), was one of the poor victims of maternal rubella (German measles) during the first few months of pregnancy. The little girl, aged $5\frac{1}{2}$ at the time of consultation, was deaf, almost blind, partly paralysed and had a malformation of the heart. In no other child is the causal connection between a disturbed pregnancy and damage to the nervous system as clear as in this one example.

The same groups that show the highest rates of disturbed pregnancies, also are characterized by the highest figures for complicated deliveries. To them, however, is added the group of epileptics, in which no disturbed pregnancies had been indicated. The fact that, again, we find the group of infantilism topping the list with 50 per cent (some of them premature deliveries, which are known to be often followed by a general retardation of development), may mean that the figure of 16.6 per cent in the previous table, which we doubted because of the small number of cases, may not have been quite accidental after all.

Second rank is occupied, as in the preceding table, by the oligophrenic group with 25.0 per cent, a figure which justified the assumption that some of the cases, particularly the most severe ones, may not have been hereditary, but consequences of birth injury. The same may be valid for the group of epilepsies.

It might have been interesting to know, how many of the deliveries were conducted in expert manner by well-trained midwives or in hospitals, or at least by experienced female relatives, and how many were perhaps handled or even mishandled in a haphazard way under primitive conditions. We shall have occasion to give individual examples, but cannot offer any general estimate or data in this respect. No doubt, however, improved guidance and control of expectant mothers and well-developed obstetric services in hospitals and for deliveries at home, can make a valuable contribution towards reducing the incidence of brain-damaged children which, to an observer from the West, seems extraordinarily high in India.

One may be somewhat surprised to find the columns for disturbed pregnancies and complicated deliveries completely blank for the group of psychotic adolescents while in all other functional groups at least some cases have been noted. One reason for this may be lack of information. As all of the patients in this group were aged above 13, either the mothers may no longer have remembered details of the time of pregnancy or delivery, or perhaps, pre-occupied by the severe disturbances some of these young patients presented and the necessity for administering immediate help, we may not have taken the information about early infancy as diligently as for younger, less acutely ill children.

14. *The Period of Breast-feeding*

In comparison with Western countries, Breast-feeding here in India generally seems to be continued over a much longer period. Though, in spite of the rich choice in tinned baby-foods, propaganda has been made in recent years in some European countries to encourage mothers in breast-feeding, this period is seldom extended beyond a few months. The same Swiss maternity clinic already mentioned (University Clinic of Gynaecology and Obstetrics, (Basel) estimates the average period of breast-feeding at 12 weeks and regards it as quite impossible that any of the women cared for by its services extend lactation beyond 1-2 years. Here in India, however, we find children who were suckled far beyond the time when the development of teeth would have enabled them to manage other types of food. Amongst our patients, children and adults, we have seen extreme cases, in whom breast-feeding, though not as the exclusive source of nutrition, was continued up to school-age or even beyond it. One can easily imagine, that this practice may have its decisive effect on a child's development. We, therefore tried to analyse our data in this respect. Once again, however, as, particularly during the first part of the period of observation, the importance of recording such details was not fully realised, our information is incomplete. One will see from Table XIV that, in a considerable proportion of cases, particularly in the group of oligophrenia, epilepsy, infantilism and adolescent psychosis, the data are lacking. One may, however, assume that any lack of information may rather signify breast-feeding over an "average" period than complete absence or extraordinarily long persistence of lactation, as such special situations were usually signalled by the parents, the one regretfully, the other proudly, even without explicit inquiry. So it is unlikely that amongst these unknown cases

there might have been some that could have swelled the ranks of children who were breastfed over an unusually long period. As their percentage is calculated with regard to the total group of children and not with regard to those known to have been breastfed, any additions from the unknown cases to the group of breastfed children might only possibly increase, but not lower this percentage.

We find that, of the total of children, 28.3 per cent have been breastfed beyond the first year, 12.0 per cent beyond the second year. These figures are just about doubled for the group of infantile psychosis and, as far as lactation beyond one year is concerned, significantly exceeded in the group of neurotics. Even in the group of psychotic adolescents, we find a rate higher than in any of the congenital-organic groups (except the small organic group in which the one single case amounts to 33.3 per cent). The only group in which we find no evidence of prolonged breastfeeding is that of infantilism, which, as we have seen earlier, more often conforms to the pattern of the congenital-organic section. The impression that prolongation of the lactation period might contribute to the development of functional disorders seems further to be confirmed by the fact that, in the oligophrenic and epileptic groups, quite a few cases with the most considerable prolongation of breastfeeding were children with functional complications.

One remarkable fact seems to be that most of the children who have been breastfed beyond one year, come from Hindu families. Their percentage amounts to 88.1 per cent of all cases, while the share for the Hindus in the total material is only 70.7 per cent. Even in the group of neurotics, where we find the most considerable share of the Muslims with 33.3 per cent against only 53.7 per cent Hindus in the total material, 85 per cent of the cases of prolonged breastfeeding occur amongst Hindu children and only 15 per cent amongst Muslims. Only one Sikh child and no Christian child has been breastfed beyond one year.

Convincing, however, as all these figures may look, at least to an observer from the West, they gain a quite different significance, if an attempt is made to compare them with conditions in a general population. Again it was Dr. (Miss) Engineer, Head of the Dept. of Obstetrics and Gynaecology of Lucknow Medical College, who kindly contributed some figures for comparison. According to her, 70 per cent of the mothers who come for delivery at Queen Mary's Hospital continue breastfeeding their children beyond the age of one year, while in our material this group only amounts to 28.3 per cent of all mothers and to 48.3 per cent of those who were known to have breastfed their children. One must, however, add that, if breastfeeding for 18-24 months, as Dr. Engineer estimates, is the normal average period of lactation, more cases falling into the category of breastfeeding beyond one year and up to 2 years might be contained in our group for which no information was given. Furthermore, as often the limit for breastfeeding a child is set by the next pregnancy or delivery, one might ask, whether the mothers who attend Queen Mary's Hospital have perhaps already been taught to "space" their pregnancies, while in our material there might be some children who,

before the era of family-planning, had to leave their place at the mother's breast to a younger sibling more quickly. Even then, the figure is likely to remain rather below that given by Dr. Engineer. One might then possibly have to reverse the point of view completely and put up the thesis, quite familiar in the West, that it is perhaps lack or premature termination of breastfeeding rather than that is likely to provoke emotional disorders or at least may indicate a lack of motherly concern which will have its consequences in other respects too.

There remains, however, the group of mothers who continued breastfeeding beyond the second year. This, in Dr. Engineer's material, amounts to 10 per cent only, while in our group, with 12.0 per cent, it is slightly higher. A percentage significantly beyond this "normal average" of 10 per cent is then obtained with 31.2 per cent in the group of infantile psychosis, which therewith keeps its prominent place. The groups of epilepsy, with 15.8 per cent and that of oligophrenia, with 12.5 per cent also rate perceptibly higher, while the group of neurosis and that of postencephalitic states only remain slightly above average with 11.1 per cent and 11.4 per cent respectively. It may, however, be noteworthy that 6 cases in which oligophrenia and epilepsy are combined with neurosis, i.e. a share of 24 per cent of these 2 combined groups, belong to the category of children breastfed beyond the age of 2 years, which brings the figure for neurotic cases (pure and combined) up to 15.2 per cent.

The corrections which we had to make in our interpretation of the figures for what the European author assumed as "prolonged breastfeeding", after receiving the figures from Lucknow Medical College, illustrate very instructively, how important it is to weigh one's figures against averages for a "normal population", wherever this is possible. Still, at least with regard to breastfeeding beyond 2 years, our conclusions do not quite lose their value, though we might have to admit that a mother remaining behind the customary Indian average of 18-24 months' breastfeeding may be sinning by omission, where in the West she would already be regarded as deviating from the average by excess, and that therefore one might also have to regard absence and short duration of lactation as possible causes of disturbed emotional development. How far such cases may at the same time be examples of early neglect or separation, will have to be examined in individual case-histories.

Indian breastfeeding practices differ from the West not only with regard to length of the period, but often also to the lack of any time schedule for the individual feeds. Some modern, emancipated mothers may have taken to the Western pattern of only feeding a child at certain times fixed according to the baby's age and possibly followed by weight-control to make sure that the child has had the full quota. More traditional mothers, however, seem to regard their store of milk not only as the necessary source for the child's nutrition, but also as a convenient "tranquilizer". Whenever the child shows any signs of restlessness or discomfort, he is immediately put to the breast, with little concern, whether any milk is actually obtained. We have heard, from grown-up patients, that even a grand-mother will at times let the child suckle her dry breasts just

for keeping him quiet. In this way, no doubt, the child is allowed for months or even years after birth, to continue in a world in which need and desire are immediately matched by real fulfilment, and of which embryonal existence is the prototype. The fact that a child should gradually develop the ability to bear frustration, to wait for fulfilment, but also to trust that, after the delay, one can count on the punctual satisfaction of the need, often seems to be ignored by Indian parents. In other respects too, this pattern of trying to spare children frustration and postponement of fulfilment, continues throughout childhood to a far higher degree of permissiveness than European parents would consider as wholesome. Consciousness of oneself as a separate ego who has to come to terms with surroundings that do not always closely match the needs, however, is mostly gained in situations in which frustration or resistance is felt. One can, therefore, imagine that this tendency to provide immediate fulfilment to children, not only by continued and unregulated breastfeeding, but in many other respects too, is likely to have important consequences on the development of independence, self-reliance, ability to digest and assimilate,—not only physically, but also intellectually and emotionally!—and perhaps of what originally is meant by the Hindi expression “swasth”, i.e. standing by and on oneself.

To be at one with the whole of creation, to discard individual limitations, attachments and fixed forms, is of course one of the ideals of traditional Hindu Philosophy. It is, however, doubtful, whether the dualism of “I” and “not I” can really be overcome by persisting in an almost embryonal world in which, thanks to immediate wish fulfilment, the two were never even experienced as separate ! One should think that a really knowing and responsible attainment of this supreme oneness, on the contrary can only be achieved by going through a stage at which one has felt the painful gap, between need and satisfaction and the adamant resistance which hard reality can put up against one’s phantasies and aspirations. The more, however, a child is prevented from learning to bear with these necessities of reality and to overcome them by determination, inventiveness and, at times patient bearing, the more may he be likely to escape into phantasy or to build up neurotic excuses and defences, if, on leaving the excessive protection of the parental home, he at last no longer can avoid coming up against frustration and resistance. In this respect, the high rate of prolonged breastfeeding in the groups of neurosis and infantile psychosis may have a very important significance, which will have to be examined in greater detail, when these groups are discussed separately.

While, thus, this apparent excess of maternal devotion manifested by prolonged and unregulated breastfeeding certainly may render very doubtful services to the child in the long run, one may even doubt, whether the short-range motives of such mothers are really exclusively determined by a wish for the child’s welfare. In stating the benefits which the mother herself derives from continued breastfeeding, we may not go quite as far as the student, who enumerated the advantages of breastfeed over top-feed as follows [quoted in “Souvenir Volume of XV Annual Conference of Indian Psychiatric Society 1962 (13)]: “(1) It is free of cost, (2) it is available all the time, (3) you don’t

have to prepare it, (4) during summer it does not curdle (5) cats can't get it" ; but it is obvious that even from a merely practical and economic point of view, this natural source of infant nutrition saves the mother a lot of trouble. Beyond this, however, continued and unregulated breastfeeding can benefit the mother, more than the child, in very subtle psychological respects too.

If one watches some Indian parents, particularly mothers, together with their small children, one often gets the impression that the empathic link between them is so close, that any discomfort of the child also quite immediately affects the mother. Calming the child's crying or restlessness, is therefore often not so much undertaken purely in the interest of the child, but in order to allay the mother's own anxiety and inability to bear the frustration of seeing her child unhappy. This again brings us up against the problem of a lack of those individual boundaries which allow a person to meet a situation objectively, with a certain emotional detachment, and to differentiate between what the need of the other person or the situation as such calls for and, on the other hand, the way it affects himself. Wherever there is a strong empathic link between mother and child, or in any other personal relationship, these issues are easily confused and, what is undertaken merely to relieve the effect of empathic participation in oneself, may impose as motivated by altruistic concern. In some women, as we have observed in some of our adult patients, breastfeeding the child quite obviously procures vicarious enjoyment to the mother, who identifies and, in cases of psychosis, even confounds herself with the child.

The same lack of individual consciousness and limitation lies at the root of another subtle aspect of prolonged breastfeeding : When treating psychiatrically disturbed women who were still breastfeeding their more or less small infants, we were often put before the decision of either allowing the patient, possibly a very psychotic woman, to continue lactation, at the risk that some of the drugs might also reach the child's organism through the milk stream, or to wait with administering full doses of medication until the child would be weaned. Gradually, the author had to learn that any possible harm to the child through sedatives or tranquilizers was often by far outweighed by the upsetting effect which prevention from breastfeeding could have on the mother. Giving love, to many Indian mothers, seems to be practically synonymous with giving food. Being deprived from this obvious means of proving herself as a good and loving mother, the sick woman, possibly already threatened by doubts and guilt about negative feelings for the child emerging from the unconscious, loses her last concrete assurance that, after all, the "good mother" in her triumphs over the dark forces. This may precipitate her into even greater psychotic chaos.

We can, however, push the subtle analysis even one step further : Breastfeeding-to a young woman, may not only signify an assurance that she is a "good mother", but it may in some cases even be the only solid and undoubtable fact that identifies her as a mother at all. The lack of individual limitation brings with it the danger that a person "is", what he has to represent to the outward world and perhaps to his own

self-respect, not because he consciously has assimilated this aspect of his personality, in other words "made it his own", but simply because circumstances, opportunities, necessities constellate him into a certain pattern. This is, perhaps, what one young patient, quite significantly one of the eldest sons whom we have sketched earlier, called "a negative existence". If a "negative existence", to borrow the young man's rather ingenious term, is robbed of the "mould", the support and confirmation which he receives in any role or even in his existence as such through the outward circumstances and opportunities, he will, so-to-speak, lose his shape or even feel threatened by complete annihilation. Being unable to be "a light to himself", he finds himself in the dark, when the outward lights are extinguished, and this is likely to throw him into panic. Breastfeeding, to a mother who is on the verge of disintegration, may be the last sign of reassurance and confirmation, not only of her role as a mother, but possibly of her existence as such.

One can imagine, how heavy a load is thus placed on the child right from the start of life : instead of being sheltered, so-to-speak "illuminated" by the mother's presence, the child himself has to protect, define, lighten up the mother's unauthentic, "negative" existence ! Where there should be giving, there is taking ; where there should be protection, there is exploitation. No wonder, that a child exposed to a situation of this kind may either remain a helpless appendage of the mother or, on the other hand, may withdraw into a wall of autistic isolation to save himself from being swallowed up. As these two groups of behaviour, empathic-symbiotic clinging and autistic isolation, are amongst the typical features of infantile psychosis,—and possibly in some more disguised form also of adult psychosis !—we have every reason to investigate very carefully the high incidence of prolonged breastfeeding in the group of psychotic children, when we come to the detailed study of this group.

That, on the other hand, the mother herself may resort to autistic withdrawal and seclusion and then neglect the child and resent breastfeeding, will later be illustrated by two of the female psychotic adolescents who were already married and whose reactions to motherhood we were able to observe.

15. *Toilet Training.*

Any study on emotionally disturbed children in the West would probably devote a quite considerable chapter to the question of toilet training. In this respect again, we find a very permissive attitude here in India. Few of the mothers, unless of the sophisticated modern type, who keep Western textbooks on child-rearing on their shelves, are able to indicate, when the children had fully learned to control their excretory functions. In severely disturbed children of an age beyond 5 or so, parents signalled the inability to announce toilet needs. So, in the individual diagnostic groups, we have collected some information on this subject. The only two children, however, who were brought for consultation explicitly and in first line because of bed-wetting, were the 8 year old son of an Anglo-Indian lady-teacher and a 5½ year old

American girl ! In all Indian children, wherever any lack of sphincter control or, as one of the father's expressed it, "no sense of urine and latrine", was amongst the symptoms, it was only mentioned casually, as an issue of secondary importance, often less as a behaviour disorder than as proof of deficient intelligence.

Not only amongst our small patients, but also amongst the "healthy" children who happened to accompany sick relatives to the Center, there were quite a few, up to school-age, who liberally voided their excrements all over our outpatient-department, without causing the slightest alarm or embarrassment to their parents.

16. *Early Neglect and Separation.*

In recent years, the importance of maternal neglect or separation of the baby from the mother, enforced e.g. through hospitalisation of the one or the other, has been recognized as an important cause or at least contributing factor of emotional disturbances, not only in children, but with effects reaching right to adult-age. One even came to recognize in Western countries, that all the hygienic and germ-proof isolation of sick babies in hospitals could cause great harm, and many children's hospitals have considerably relaxed their rules which used to limit parents' visits to a strict minimum, perhaps only to a hurried peep at their child through the glass-panes of an isolation-box.

In this particular respect, India has conserved, perhaps unknowingly, a practice which, though physically perhaps unhygienic, comes up to what the West has now accepted as an important requirement for mental health. Most children admitted to Indian hospitals are accompanied by a family-member, preferably the mother. Again, however, as with regard to prolonged breastfeeding, one may ask, whether this practice, apart from being necessary from an administrative point of view with the present organisation of hospitals, is always in the interest of the child and not much rather maintained by the mother as a defence against her own anxiety. Some of the mothers whom we have seen huddled up and anxiously clinging to the child in the small cot allotted for the latter, seemed to be much more in need of being helped and encouraged than capable of giving care and reassurance themselves.

To describe the possible advantages and disadvantages of this practice of hospitalising children together with their mothers, perhaps in comparison with modern experiments in the West, will be the task of clinical paediatricians.

In this context, we shall only be able to point out a few individual examples of early neglect and separation, some of them quite gross, when we come to the study of separate diagnostic group. The figures we tried to collect, indicate that early neglect and separation, either due to compelling circumstances, such as illness or even death of the mother, but in some cases also to lack of experience and interest on the mother's part, occurred mostly in children of the functional groups, and there again relatively most frequently in the group of infantilism and that of infantile psychosis.

A pattern which we noted several times was characterized by the mother's explanation : "The child was so quiet and never seemed to want anything, that we did not have to bother about him." Years later, it may be difficult to distinguish in such cases, what may have been primary cause and secondary effect : whether the mother's disinterested attitude made the child withdraw at an early age, or whether an actual congenital dullness of the child reduced the mother's interest, or whether both factors acted in a kind of vicious circle.

One particular form of neglect may perhaps be seen in the mothers who administer opium to their children so as to keep them quiet ! We have seen several cases, amongst the children and adult patients, who were victims of this custom, which apparently is by no means extinct in India !

As early neglect for psychological reasons is likely to be closely related with a rejecting attitude of the mother, we tried to find out, how many children were "unwanted", either as such or at the time they were born or because their sex did not conform to expectations. As many mothers of the traditional Indian type, true to the idea that a child is sent by God and therefore always to be welcomed, are very little conscious of their more personal motives existing apart from and perhaps against this officially sanctioned attitude, outright admission of thoughts of rejection were only to be expected from the more emancipated mothers. Definite statements of this kind were made by 9 mothers, all belonging to the group of neurotic, infantile and infantile psychotic children, again with a marked accumulation in the last group (5 of the 16 children with infantile psychosis !) In the congenital-organic group, no particular care was taken to note this extreme rejecting attitude. We know, however, that in 2 cases of oligophrenia combined with functional disorders, the mothers had attempted abortion during pregnancy of this child, a situation which we found indicated only in one other case, belonging to the group of infantilism.

A rather surprising fact is that, neither instances of early neglect and separation, nor of explicit rejection or even attempted abortion are to be found amongst the psychotic adolescents. We have already pointed out earlier, that information about early infancy, in these children aged 13-16, may not be as complete as for younger children. We can, however, not quite exclude, that the lack of such observations in this group may have its significance.

17. *Parental Attitudes.*

The last few sections have already led us quite deeply into considering the effects which the attitude of the parents, particularly of the mother, produces on a child's development. It will now be our task to study this problem more thoroughly.

A first investigation of "parental attitudes" was attempted in 85 children examined by us between April 1956 and January 1959 [Solomon and Hoch : "Parental Attitudes" (14)]. In that paper, we did not only try to find out, which parental attitudes

predominate with regard to organically damaged and functionally disturbed children, but also to correlate the parents' attitude towards the child with their attitude towards consultation and treatment. As our experience had made us suspect, we found that open rejection was more frequently expressed by parents of girls, and that parents' attitudes with regard to organically and congenitally handicapped children were in general more tolerant than with regard to neurotically disturbed children. Furthermore, our tables and graphs confirmed that those parents whose harmful attitudes, proceeding from their own neurotic problems, seemed to be most responsible for a child's emotional disturbances, were amongst those who were least ready to cooperate in a really thorough treatment. In particular the parents who were characterized by placing high demands and ambitions on their children, were also those who expected treatment to consist in an instantaneous magic cure.

In the present study, we tried to investigate mainly the variations in parental attitude with regard to the diagnostic categories and, summing these up, with regard to the congenital-organic, the functional and the combined groups. (See Graphs VII and VIIa and Table XV).

For purposes of tabulating and calculating, the great possible variety of subtle shadings in parental attitudes naturally had to be reduced to a few main types. Classification was not always quite easy, as we had to blend the parents' own account of themselves and each other with the result of our own observations of their behaviour. In some cases, we were able to see both parents, in others only either father or mother or even neither of them, when the child was brought by some other relative. Any account given by the child him—or herself, could rarely be taken as a true and explicit indication of the parents' attitude. Children are extremely loyal and reticent, where any betrayal of those, on whom they necessarily have to depend, is concerned. On the other hand, certain children are quite clever at representing themselves as poor victims of parental neglect and cruelty, just in order to gain sympathy. At times, however, it was possible to get some insight into the relationship with parents by indirect methods of exploration.

Cases in which the father's and the mother's attitudes were obviously diverging, were listed as "parents divided". A separate graph (Graph VIIa) tries to illustrate the combinations of attitudes occurring in this group.

A word of explanation may be necessary to characterize the types of attitude chosen as representative, and the order in which they have been listed. If one wanted to make a very rough classification, one probably could simply list "acceptance" and "rejection". One would, however, then come up against many situations in which outward appearance and actual inward attitude might not be concordant and which one would be at a loss to place into one or the other category. This applies particularly to the 3 attitudes which top our list: "Expecting too much", "pampering" and "over-anxiousness." Though at first sight one might think that parents who manifest attitudes of this kind are particularly concerned and accepting, one need hardly consult

learned works on depth psychology to realize that all these 3 attitudes do not, in fact, represent a primary and unconditional acceptance of the child as he is, but are in some way either an overcompensation for some tendencies of rejection and disappointment or at least tinged by the parents' selfish aspirations to find satisfaction of their pride, ambitions and emotional needs in and through the child.

In this way, an excessively pampered child, far from receiving real concern, may, in a suitable way, (as we have already shown with regard to prolonged breastfeeding), be fed upon rather than fed. Equally, an overanxious mother may, merely in the interest of her own security, restrict the child's freedom of development without providing true shelter for him. The child who is exposed to excessive parental demands and expectations, finally exists with his real needs and problems only as a neglected shadow beside the ideal "edition" which the parents see in him or want to make of him. So, in all 3 cases, it is not really the child as he is, with his particular needs for care, shelter and stimulation for development, but in a way a phantom-creature, born of the parents' own needs and desires, which gets the care and attention, while the "real child" with all his potentialities, may suffer neglect or rejection.

This problem of true and apparent care is of such importance in our present age of exploitation and economic "usefulness", that one of the greatest living philosophers of the West, Martin Heidegger, has devoted and still is devoting, considerable attention to formulating it in its various aspects. To him, care of the creatures and objects that come within the sphere of light of one's existence, is the foremost destination of man. This call, however, is all too frequently neglected or misunderstood. Even where one meets signs of someone's "taking care" of a fellow human being, one will have to distinguish sharply between two main attitudes this "care" can spring from. Heidegger characterizes them as, what one might call in English, "intervening" and "anticipating" care. (As in the case of many of the carefully worded German terms Heidegger uses, always "taking care" of the original meaning the word itself wants to unfold, his original terms in this case somewhat suffer by translation into English. The main sense, however, as will be seen in the context, can be rendered by the translation chosen). The term "intervening", though perhaps a bit unusual, has been chosen deliberately, as it comes not only closest to the German "einspringend", but also suggests some affinity with "interfering", into which, indeed, "intervening" all too easily degenerates.

By this "intervening care" is meant, what the average human being would understand by "taking care": to do or to provide whatever may be needed by the person to be taken care of. One thus replaces or even displaces the other person from the point at which he might "take care of himself", and he gets used to take over the finished result of the "intervention". In this way, though perhaps in a very subtle manner, he risks to become dependent on and dominated by the one who "takes care". What Heidegger calls "anticipating care", on the other hand, is a concern for the other person's welfare, which, rather than "intervene" or even "interfere" in the other persons

momentary needs, tries to run ahead and to discover coming needs, so that the one to be taken care of in this way may become ready and free for what lies ahead in his existence [See Heidegger (15)] Or, in other words, the concern of "anticipating care" is "the perfection of a human being, his becoming that which in his freedom for his very own possibilities he can be" [Heidegger, *loc. cit.* p. 199 (15)].

Though these learned formulations of the distinguished existential philosopher have a much wider and more general implication than that which interests us at the moment, one will readily see that any true care and education of a child should have as its ideal this "anticipating care", and that the 3 attitudes characterized by "expecting too much", "pampering" and "overanxiousness" all, in some way or other, offend against its true spirit ; Expecting too much and overanxious restriction by neglecting, distorting or suppressing what the child's "very own possibilities" would be ; pampering by never getting beyond a shortsighted "intervening" and interfering type of care, which leaves the child unprepared to take over responsibility for himself at a later age.

While, what we have termed as "concern, acceptance", represents the "golden means", an attitude in which care for immediate needs and foresight for the development of the child's potentialities are more or less harmoniously blended, the three attitudes listed below this middle column fall short even of the mere average "intervening" type of care. "Inconsistency" is characterized by acceptance or even pampering alternating, according to the parents' mood, with angry rejection or careless indifference ; carelessness and neglect also include, in some cases, lack of understanding for the child ; in the worst cases of rejection, the child's very existence may be an object of constant disappointment and irritation and even of open curses and death-wishes.

After having thus characterized the attitudes listed and having shown their meaning in a wider context, we can turn to Table XV and Graphs VII and VIIa. One caution, however, has to be kept in mind : We are only studying the attitude of parents who, either for the child's real benefit or for relieving their own anxiety and annoyance, took the trouble to consult a psychiatrist, which in itself betrays a certain amount of concern and willingness to take care. We have to assume that, particularly amongst the parents of congenitally and organically disabled children, the most careless, neglectful and rejecting parents would not even do that much for a child. So, once again : our tables are only valid for those parents and children who actually came for consultation and cannot be taken as a general indication for attitudes prevailing with regard to handicapped children in the population of India or any particular part of the country. Equally, the parental attitudes that seem to have been mainly responsible for functional distortions in their children, cannot be regarded as most typical and frequent in a general sense. As we had pointed out in the paper mentioned earlier [Solomon and Hoch (14)], the very parents whose own emotional problems seemed to be most involved in their children's neurotic or psychotic disturbances, were also the least willing to co-operate in any treatment plan. We therefore have to assume that, amongst the children *not* brought for consultation, but equally suffering from emotional trouble, we might

find some whose parents manifest attitudes of an even more extremely or intensively harmful kind. Products of such attitudes might possibly be found amongst our adult patients who have come for treatment themselves, when no longer dependent on their parents, or possibly brought by the family when they had degenerated into a "nuisance" that could no longer be tolerated.

On inspecting now the distribution of the various parental attitudes in the diagnostic categories, one will do well to see first the Table XV, in which the figures for the groups of purely congenital-organic affections, the groups of functional disturbances and the combinations between the two are summed up. The most striking fact is perhaps that an accepting attitude, as we had already noted in the 1959 paper (14), is far more frequent in the group of children with purely, congenital-organic handicaps. Next in size, but with a considerable distance, comes the figure for "divided" parents, and, close to it, that for "expecting too much." The remaining figures in this column are all below 10 per cent. The 3 attitudes listed first, which we can perhaps sum up as "excessive concern", are represented slightly more with a total of 24.3 per cent than the 3 attitudes which we might sum up as "lack of concern", and which sum up to 16.6 per cent.

We find a very different picture in the second column, in which all those cases have been assembled, in which a congenital-organic disorder was overlaid by functional disturbances. "Excessive concern", particularly in the form of pampering, and "lack of concern", mostly in the form of outright rejection, each amount to 42.5 per cent, i.e. to twice as much as all harmful attitudes taken together in the previous column for purely congenital and organic cases. In other words, we can say that mentally deficient, postencephalitic and epileptic children tend to develop accessory troubles of functional type, if their parents cannot accept them as they are. It even seems that, if only one of the parents has an accepting attitude or shows at least concern in its excessive form, the child can manage to develop fairly harmoniously. While in the "pure" congenital-organic group the number of cases with diverging parental attitudes is second in size, no such cases were noted in this combined group. One may argue that certain attitudes, like "expecting too much", "overanxiousness" and "inconsistency" are represented at a slightly higher rate in the pure congenital-organic group than in the combined one. We have, however, to consider that, in the first group, there are some cases of extreme mental deficiency, in whom any emotional reaction to faulty parental attitudes could hardly be expected or, if present, might not easily be distinguished from the fundamental trouble. One most significant fact remains: even if we look at the detailed graphs for the separate diagnostic categories (Graph VII and VIIa), the column for acceptance always loses its bulk considerably, when the cases combined with functional disorders are represented separately. In these detailed groups, the percentage for "acceptance" is highest for postencephalitic children. It is fairly plausible that a child who has been physically and mentally handicapped through an acute febrile illness, i.e. a very obvious cause, open to rational understanding, may be the object of more sympathy and natural

concern than a child abnormal from birth and about whose defect the parents may entertain strange superstitious or perhaps guilt-feelings.

After seeing in these two columns already discussed that lack of parental acceptance in some form or other seems to be correlated with the development of functional troubles in congenitally and organically handicapped children, one may be somewhat surprised to find the figure for "acceptance" slightly higher in the purely functional group. The reason may possibly be that handicapped children depend more on their parents than physically healthy ones, who can derive security and stimulation from other sources, but who also may be more exposed to harmful influences outside the home. Therefore, distortions in the parental attitude with regard to handicapped children with colour their world more totally and be responsible for more deviant emotional reactions than any other factor.

Even so, with the exception of the group of "infantile psychosis", in which we do not find a single child who enjoyed acceptance from both parents, "acceptance" accounts for the biggest percentage in each group. One may ask, whether, what imposed as "acceptance", may not have been hiding some subtle harmful attitude. This cannot be excluded. On the other hand, as we just hinted, such factors as sibling-rivalry, unique position in the sibling-row, influence of other family-members, for the married girls also lack of acceptance by the in-laws, then in particular also absence from home, either of one of the well-meaning parents or of the child himself, furthermore difficulties in school-life, will have more of a chance of acting on physically healthy and mentally fit children than on the congenital and organic cases with their relatively restricted life-sphere.

Still, one question, already stimulated by our investigations on the role of the joint family, has to be asked, and we propose to analyse and illustrate it in detail for the group of neurotics later. Is it perhaps the very transition from a sheltered, peaceful and harmonious home into a harsh, competitive, frustrating world outside that may precipitate young people into emotional dysbalance? Could the helpless ignorance of even well-meaning and concerned parents about this new world, which their children have to face, perhaps turn, what imposes as normal concern and acceptance, into something that lacks in foresight and "anticipating care"? The fact that, in the group of neurotics, the share of children whose main symptom was anxiety, is greatest in those who enjoyed parental acceptance, and again figures predominantly in children from joint families, seems to point in this direction. Anxiety, as we have seen in our total material of children and adults, seems to be a very fundamental situation, at the root of many emotional disorders. The moment of its first overwhelming manifestation often appears to be little related to any significant outward cause. One sometimes gets the impression that it may depend more on some kind of inner growth that proceeds according to its own rate and law and may one day suddenly prove to be out of harmony with the "outward" development, thus precipitating a crisis. The child who has to venture out into a complicated, demanding and possibly corrupt world on leaving the

shelter of a peaceful, harmonious family-life, may, just because he was so well sheltered, not be ready to stand on his own yet. Moral standards, high aspirations, which within a similarly tempered family atmosphere he may have been able to hold up without even questioning them, may suddenly put him at variance with his surroundings, who no longer support, but perhaps ridicule or even obstruct him in following ideals that have not become his own yet. He may have learned to "digest" what was offered at home in a ready-made form, almost as "pre-digested" and congenial as mother's milk ; but he may not be able to assimilate, to transform into his own substance, what presents itself as "foreign matter", once he leaves the secure circle of the family.

At any rate, the fact that we have a considerable number of children in the functional group who have enjoyed, what seems to be normal parental concern and acceptance, again illustrates that the present period here in India is indeed one of emergence, of contrasting influences and lack of security.

Table XV further shows us that, more than any harmful attitude shared by both parents, divergence in parental attitudes seems to be responsible for functional disorders. This proportion reaches its maximum, 43.7 per cent of all cases, in the group of infantile psychosis, which once again proves to be a collecting ground for extreme influences. Furthermore, the divergent attitudes, as shown in Graph VIIa, only include acceptance in 2 out of 7 cases, in both from the side of the father, but in no single case by the mother. As ambivalence, being drawn to both sides in any alternative, is an essential feature in psychosis with schizophrenic trends, being exposed to contrasting influences from the parents may possibly play a significant role in this small group.

These Graphs (VIIa), indicating the combination of divided parental attitudes, may not be quite comprehensive at first sight. A few explanations may help to read them with profit : The middle column, both the horizontal and the vertical one, represents acceptance at least from one of the parents, (horizontal the mother, vertical the father). Through this axial cross, the graph is divided into 4 quarters. Whatever cases are drawn, in the form of small black squares, in the left upper quarter, were subjected to some form of excessive concern from both sides, e.g. exaggerated demands by the father, overanxiousness or pampering by the mother. The cases in the right lower quarter, were victims of lack of concern from the side of both parents. One will see that this sector is only occupied by 2 cases : one in the group of neurosis, one in that of infantile psychosis. One may argue that, where neither parent is interested in the child, the idea of consulting a psychiatrist may not even arise. The column of "inconsistent" attitude, which is occupied in both these cases, allows, however, for moments of concern at least by one of the parents. The upper right quarter indicates excess of motherly concern with neglect or rejection by the father. This column is only occupied by 2 cases in "infantile psychosis". The left lower quarter, finally, contains cases in which maternal rejection is coupled with excess of paternal concern. It is rather interesting to note that, in the groups of oligophrenia and postencephalitic states, the vertical central axis, indicating acceptance by the father, is more heavily

occupied than the horizontal one. Added to this, is the complete emptiness of both quarters on the right, which would indicate neglect or rejection by the father. One may argue that mothers spend more time with a handicapped child and are therefore more harrassed and worn-out by difficulties and conflicts, while the fathers, often only sharing the family-life for short moments, can easily afford to be more generous and tolerant. We have, however, seen a few cases, in which the fathers quite personally took upon themselves the greater part of the actual physical care of the handicapped child who had been neglected by the mother. We shall give illustrations of this kind in the chapter on oligophrenia.

Having found in our earlier study that attitudes of more or less open rejection were admitted more frequently by parents of girls than by those of boys, we tried to calculate the proportion of boys to girls in the columns for neglect and rejection. One will remember, as a point of comparison, that the proportion of boys to girls in the total material is almost exactly 2 boys to 1 girl. Again for the total material, the proportion of boys to girls in the two columns for rejection and neglect is 1.7 : 1, i.e. weighing slightly less for the boys. We have, however, to remember that the girls are relatively less frequent in the congenital and organic groups, where rejecting attitudes (pure and combined groups taken together), are far more frequent than in the functional group, where we have 1.4 boys to one girl. If we only consider the relatively few cases of rejection and neglect in this latter group, the functional one, 6 of the 11 cases of neglect concern girls, and the two cases of complete rejection are divided up equally between the sexes, i.e. we find a proportion of 0.85 boys to 1 girl, which leans more towards the girls' side than the sex distribution for the functional group as a whole.

With the still existing cultural prejudice against girls, it would seem plausible that a girl can become the victim of neglect and rejection, even if she is healthy and mentally developed, while a boy would only be exposed to openly negative attitudes, if his being physically and mentally handicapped deprives the parents of staking their pride and ambitions on him. We find, in fact, that rejection and neglect are distributed between the sexes at a rate of 2.6 boys to one girl in the congenital-organic group, corresponding fairly exactly to the proportion for all cases, amongst whom boys outweigh girls at the rate of 2.7 : 1.

To sum up once more, what the tables and graphs indicate : Total acceptance by both parents is most frequent in congenitally and organically handicapped children. Attitudes harmful by excess of concern are a little more frequent than those characterized by lack of concern. Where the parents' attitude diverges, the father in most cases has a more positive attitude than the mother.

The cases in which functional disorders were superimposed on congenital and organic affections, show the lowest percentage of parental acceptance. Harmful attitudes are equally distributed between excess and lack with a particular accent on pampering on one side and total rejection on the other. No divergent attitudes were found in this group.

In the functional group, divergent parental attitudes take the biggest share, with a maximum in the group of infantile psychosis. The relatively high percentage of accepting parents is rather surprising, but may find its explanation in the fact that influences other than those of the closest family circle may contribute to emotional conflicts and distortions. Excess of parental concern, particularly in the form of over-anxiousness, predominates over lack of concern in this group. Complete, open rejection is only signalled in two cases of neurosis.

Girls with purely functional trouble are more often exposed to rejecting and neglecting attitudes than boys, while amongst the congenitally and organically disturbed children, the sex distribution for neglect and rejection corresponds very closely to that for the whole group, in other words : boys and girls are equally affected by these extreme negative parental attitudes.

18. *Physical Defects in the Children Examined.*

While, up to now, we have analysed mainly those factors that characterized the environment into which the children were born and which was to shape their early years, we now have to discuss a few features of the children themselves.

Starting again as much as possible from the periphery and from the earliest age, we propose to study first the physical state of health of the children examined. Part of the data which we are going to use for this purpose, might just as well have been presented in connection with anomalies of pregnancy and delivery, as they concern the presence of malformations, which mostly are congenital. Also congenital are some of the organic affections of the central nervous system, of which we found discrete signs not only in the group which we call "congenital-organic", but also in some of the children with functional disturbances. What we have listed under "general physical disorders", comprehends either consequences of an earlier physical illness, as e.g. rheumatic heart, bone deformations due to rickets, corneal opacity after small-pox, or then a state of physical illness which was found at the time of examination, but which did not form an essential part of the psychiatric disturbance or a psychosomatic manifestation or conversion symptom due to the emotional disorder itself.

All these 3 types of physical disorder taken together, (Table XVI) were present in 71.1 per cent of our total group, 75.6 per cent in boys and 61.7 per cent in girls. It is however, clear that a great part of this rather impressive figure will be due to affections connected with the basic trouble in the congenital-organic group. There, we find a total figure of physical disorders amounting to 85.1 per cent, again slightly higher in boys with 86.5 per cent against 81.2 per cent in girls. In all functional groups taken together, we only find 51.7 per cent of children with physical disorders : 56.8 per cent of the boys, 44.4 per cent of the girls. This persistent difference between the sexes is also found in the total figures for "general physical disorders" (12.1 per cent of boys,

10.3 per cent of girls), signs of organic damage to the central nervous system (50.7 per cent of boys and 42.6 per cent of girls) and dysplasias (35 per cent of boys and 22.1 per cent girls) taken separately. Of course one has to remember that boys are represented more strongly in the congenital-organic group than in the total material. If we keep account of this by calculating the figures for each of these categories separately, we still find relatively more physical defects in the boys as far as general physical disorders are concerned, and also for signs of organic damage to the central nervous system in the congenital-organic group and for malformations in the functional group, while there is a slight predominance of girls in the 2 remaining categories, i.e. organic disturbances in the functional groups and dysplastic states in the congenital-organic groups. Both these differences, of only 1.5-2 per cent, are so small, that they cannot be considered as significant. We thus are put before the fact that, with the exception of these last two categories, in which relative figures for boys and girls can be taken to be more or less equal, all other categories of physical disorder indicate a predominance of boys. A particularly striking figure is that for dysplasias in the functional group, which is exclusively made up by boys.

This difference in distribution of organic and dysplastic states between the boys and girls amongst our patients, which is also reflected in the total rates for boys and girls in all congenital-organic groups, was something that already drew our attention, when we wrote a first report in February 1959 [Hoch (16)]. At that time, we commented on it as follows: "Though there are certain theories maintaining that a boy's organism is more fragile, not only in childhood, but already during pregnancy, it is quite impossible that this factor should be responsible for so unequal a distribution of physical and mental disturbances. It is far more likely that these figures are due to cultural factors, i.e. the higher regard and appreciation that is generally accorded to a male child in India". And later: "Unless one assumes that less care is taken to secure survival of girls (i.e. those who show some physical malformation or mental defect at birth or in early infancy), it seems legitimate to assume that they are not considered worth the trouble and expense of consultation."

Considerations of this kind have to be kept in mind, if one reads statistics on incidence of malformations in infants brought to hospitals. If, as e.g. we have seen it in a publication on the incidence of anal atresia, an Indian author maintains that, in contrast to Western text-books, the number of male newborns admitted to a hospital with a certain malformation greatly exceeds that of girls, we have no reason to regard this as the real incidence, unless the figures have been collected right after delivery in hospital. If they are derived from infants admitted after birth, particularly if the hospital is in a rural area, one might just as well suppose that girls born with a severe type of malformation may not have been considered worth any effort to secure their survival.

It may again be interesting to compare our rate of 30.7 per cent malformations in the total material with the figures kindly provided by Dr. Engineer of Lucknow Medical College. She gives the percentage of babies born with congenital malforma-

tions not incompatible with life as 1-2 per cent. The Swiss clinic already quoted gives a figure of 1.3 per cent for 1961. We have no information, what conditions are included in these rates. But even if our own figure should contain more negligible deviations, such as incomplete separation of fingers and toes, Spina bifida occulta, various irregularities of the skull, high palate and narrow nose, generally unharmonious body proportions or even some deformities that may not be congenital, but due to later affections, e.g. rickets, the difference between the two figures is too considerable to be neglected. One would naturally expect an extraordinary accumulation of such dysplastic conditions in the children of the congenital-organic groups. But even in our functional groups, the percentage, with 10.3 per cent, is 5-10 times as high as the one indicated for the newborn babies at Queen Mary's Hospital. The question then arises, whether such handicaps, though they may not be very considerable, may possibly predispose a child to functional psychiatric disturbances.

If we take a look at the columns for the individual groups, we find that again it is the group of infantile psychosis that shows the most extreme percentage of 25 per cent or, if we only count the boys, 33.3 per cent. If, furthermore, we note that, in this group, the number of children with discrete signs of organic damage of the central nervous system is highest (43.8 per cent) amongst the functional groups, this lends support to the theories which consider infantile psychosis, in particular infantile autism, as the result of organic damage to the brain.

Quite generally, one can probably assume that a child with some physical handicap, consisting in an obvious malformation or in damage to the central nervous system resulting in dysfunction of limbs or sense organs, will have to face many painful and frustrating situations, possibly also unreasonable parental attitudes, and therefore be more likely to develop emotional disorders than healthy children. Some of the dysplasias and signs of organic damage to the central nervous system which we found on careful examination, particularly in the functional group, were however so discrete that neither the parents nor the children themselves knew about them. In these cases, no reaction of the environment or of the patient himself can have been responsible for an emotional distortion in connection with the defect. We have to assume that, in cases of this kind, the discrete malformation or the subtle evidence of a damaged brain is a sign of a generally lowered resistance, perhaps an inability to cope satisfactorily with stimuli from the outside world which, for a normal child, would present no difficulties.

Possibly we may have to assume a kind of "sliding scale" of organic-constitutional and functional-acquired factors for all the conditions we have summed up as functional: Where any organic disturbance or constitutional weakness is present, relatively minor emotional stress can lead to dysbalance or even disruption, while a healthy constitution will only be overthrown by more significant emotional upsets. As, according to the data already discussed, in the group of infantile psychosis the presence of both, organic-constitutional and emotional factors is quite marked, we shall attempt to establish a slidingscale of this kind, when we come to the detailed study of this group.

As organic damage to the central nervous system can be a consequence of complicated delivery, while malformations may in some cases be due to a disturbed embryonal period, it may be interesting to compare our tables for these two factors (See Table XIII) with our figures for organic and dysplastic signs. Rather strangely, the figures for the group of infantile psychosis are quite insignificant, while they have their maximum (50 per cent complicated deliveries, 16.6 per cent disturbed pregnancies) in the group of infantilism, which, on the other hand, is much less rich in signs of organic damage to the central nervous system (33.3 per cent) and dysplasias (16.6 per cent) than the group of infantile psychosis. The answer may be that the general physical, mental and emotional retardation of these infantile children represents a total response to some diffuse damage, e.g. by premature delivery, while in other cases only a localized effect was produced.

In the congenital-organic groups, we find, as one might expect, a fairly universal correlation between relatively high figures for complicated deliveries and presence of organic damage to the brain.

This again raises the question whether possibly, with the development of improved antenatal and obstetric services, the incidence of such defects could be reduced,

Another factor that might be responsible for some of the organic signs noted is the frequent occurrence of infectious diseases with high fevers in infants. Parents often do not seem to realize sufficiently the risks which attacks of high fever mean to a small child's delicate nervous system. Only when a convulsion scares them, they may call for the doctor, possibly already too late to prevent permanent impairment of brain function. Parents' helplessness is characterized by a remark as the following: We did not dare to put ice on the child's head, when he had high fever, because someone else, to whom this had been done, had died." One now-a-days knows that, in sensitive children, the risks of convulsions in fever can be considerably reduced, not only by fighting the basic infection by chemotherapy and antibiotics, but also by antipyretics, diuretics and possibly sedatives, which can be given without much risk, as a matter of routine, even by the parents themselves, while they are waiting for expert help.

On the other hand, modern medicine does not only seem to relieve, but also claims its casualties. Amongst the organically damaged children, there are a few who developed symptoms of encephalitis after small-pox vaccination and one after anti-rabies injections. Of course the small number who become victims of this apparently still unavoidable risk, is probably negligible beside the list of deaths and permanent disabilities one would provoke by exposing children to these diseases without preventive measures. At any rate, however, caution in vaccinating may have to be exercised in children who have manifested any signs of a disturbance or particular delicacy of the central nervous system, and in those suffering from some acute illness.

Another sad chapter is that of children who, thanks to the modern drugs, have survived meningitis, particularly the tuberculous type. We shall have to present one

or two cases of this kind, in which one really doubts, whether the medical triumph of securing survival was worth all the human misery that followed from it.

Quite generally, the advances of medicine and preventive health services may mean that more constitutionally weak and possibly brain-damaged children will survive. If, however, at the same time, the world into which they are born, becomes more and more devoid of true care and shelter, a place of ruthless competition in which only the tough, resourceful and independent find a place in the sun, they may have little reason to be grateful for the achievements that have saved them from dying at an early age. If social and preventive medicine takes a pride in reducing infant mortality and increasing the life-span, it will at the same time have to provide sheltered conditions for the upbringing and, at an adult age, the occupation of those who have survived in spite of a weakness or handicap.

19. *Former Illnesses*

To an observer from the West, one of the impressive features here in India is the persistence, though in recent years greatly reduced, of such major infectious illnesses as cholera, small-pox and typhoid. While a European medical student may not see a single case of any of these illnesses during his whole training and probably also during his later practice, it is a quite usual thing here in India to find people who have suffered not only from one, but possibly from all of these infections. Again, it would probably be rather difficult to obtain suitably matched figures for their incidence in the total population. If we have undertaken to tabulate the incidence of some major infectious illnesses, of some dystrophic states and of accidental injuries in the children examined by us, this again cannot have such general value, but only possibly indicate some differences between the various diagnostic groups in our material (Table XVII).

One flaw in our calculations is that we have only listed the former illnesses as such, but not with regard to the time of their occurring. As the figures thus do not indicate, whether the illness took place before or after the psychiatric trouble was noted, any conclusions as to a causal connection between these physical illnesses and the disturbances for which the children were brought, would not be permissible. In the individual case, of course, e.g. when we hear that a child grew up harmoniously, until he fell ill with typhoid and that, after a severe attack of this illness, he started showing signs of irritability, lack of concentration, anxiety, one will be justified in concluding that the illness may have lowered resistance or that it may have given an occasion for certain emotional experiences that shook the child's emotional equilibrium.

The only assumption on the base of which comparison between the congenital-organic and the functional group may have some meaning, would be that, possibly, a same constitutional weakness responsible for the psychiatric disorder, might also dispose the child to more frequent physical illnesses and that, therefore, we might perhaps find higher figures in the former group. Against this, however, one will have to hold

up the argument that chances of exposure to certain infections may possibly be higher in functionally disturbed children who, in general, enjoy more freedom of moving about outside home than the handicapped children of the congenital organic group. The same might apply to accidents. Furthermore, one may have to realize that, in a group in which we assume a lowered resistance against infection, more children who actually contracted a disease, like small-pox or typhoid, may have died of its, so that, in spite of a higher incidence, the number of living children who have gone through the disease may actually be smaller than in a group that offers more resistance. Another factor that prevents us from drawing valid conclusions, is that of age distribution. To be quite exact in really taking account of the chances of developing any illness, one would have to relate the incidence to the sum of ages or the average age of the children in each group.

Accordingly, the group of psychotic adolescents, which only contains children aged 13-16 years, should theoretically present the highest incidence. We see, however, that the figures for this group, when compared with the group of neurosis, which shows a greater variety in age distribution, present no uniform trend. The figures for the psychotic adolescents are slightly higher only for small-pox, rickets and marasmus and for accidents, while for typhoid, we find a figure lower than for the neurotic group, and for pneumonia and liver trouble even a complete absence.

If we note that the two groups of infantilism and infantile psychosis are relatively free from infectious diseases, this may demonstrate the effects of better prophylaxis, e.g. through vaccination and general hygienic measures, of which these children of a young age group profited, while in the group of psychotic adolescents, the relatively high figure for small-pox may point to the still deficient preventive measures 10-15 years ago.

One knows that adult psychotic patients, particularly those of the schizophrenic type, are often singularly immune against physical illness. On seeing the relatively low figures for our two psychotic groups, one may ask, whether beside all possible other factors, this kind of isolation and insulation against the influences of the outward world may also have protected these children from physical illness, possibly long before their particular disposition resulted in psychosis. This, however, still leaves unexplained the extraordinarily low figures for infantilism. We cannot assume that these children, some of them quite delicate after premature delivery, were better protected than those of other groups, as, according to our tables for parental attitudes, the amount of parental care they enjoyed was in no way extraordinary.

One sees that the tables on former physical illness cannot give us much relevant information. Too many factors are involved and, ultimately, contributing causes and after-effects, and in particular any connection with the psychiatric disturbance in one way or the other, of any of the illnesses listed, can only be assessed to some extent in the individual case.

The tables may, however, have a certain value for any possible reader from the West, as they reflect a situation quite unfamiliar in most European countries and—let us hope!—also one that may have become obsolete here in India a few years hence.

20. *Education.*

As the drive for literacy, schooling and higher education takes so prominent a place nowadays, not only in national programmes, but also in the scale of values of individual Indian parents and children, one will naturally be eager to learn something about the educational standards of the children observed.

One would expect that children of parents who are enlightened enough to consult a psychiatric clinic, would also be amongst those who have recognized the value of education for their children. Our figures for the functional groups might possibly give some valid information in this respect.

More than any question of the parents' social status and intellectual emancipation, however, it is the type of psychiatric trouble of the children themselves that determines the standard of education. Figures for schooling have a quite different meaning in the group of oligophrenia and those of the congenital-organic section as a whole, than for the functional groups. In the former groups, interest would be directed towards knowing, how many children were sent to school at all, and how many were able to profit by any attempt at teaching them. Such figures, illustrated by individual case-histories, may possibly help to prove the need for special education institutions adapted to the limited capacities of mentally handicapped children.

In the functional groups, however, such problems as all too early schooling, double promotions into classes beyond the normal standard for a particular age, or, on the other hand, lagging behind for emotional reasons, will have to find their place.

Any table can therefore only have its significance within the individual diagnostic groups, and we therefore propose to leave the subject of education for the detailed study of these groups.

21. *Problems of Adolescence.*

In the chapter on age-distribution, we have shown that the greatest number of children examined came from the age-group of 11-16 years. It is therefore to be expected that problems of puberty and adolescence will play a particular role in all diagnostic groups, except of course those of infantilism and infantile psychosis.

Considered from a merely outward point of view, we have to list such situations as early marriage, which we find in one boy and 4 girls, or even only the prospect of marriage; in some of the boys an early start in working-life; in those who study,

perhaps choice of unsuitable subjects, difficulties in exams, changes to a bigger college with a wider competition, leaving home for a boarding-school or hostel. Apart from these outward factors, which mainly mark a widening of the social circle in which the child moves, puberty and adolescence bring their internal tensions : the rising of new vital energies, a wish for independence and self-assertion, the emergence of an individual conscience, all can lead to particular strain at this time of life, even if social circumstances do not place any additional burden on the young person. This can perhaps best be seen in children of the oligophrenic group : even amongst the idiots, where there is hardly any question of a widening social circle or additional responsibilities, the mere biological event of puberty can provoke increased restlessness and lack of control over the rising sexual stimuli.

Again it would be useless to sum up such difficulties for all children together in this place. According to the differentiation of intellect and emotions, each group presents difficulties of a particular type, which merit discussion in detail later on.

22. *Children's Interests*

What has been stated in the last two chapters, applies also to an investigation of the children's recreational interests. They can only be properly evaluated in close connection with the particular diagnostic groups, for which separate tables will be shown.

Such tables may not necessarily give us an idea of the spontaneous direction of the children's interests, but may merely be a measure for the possibly limited stimuli and opportunities that were available to them. They might thus give us valuable indications for the further development of recreational services for children and adolescents. These needs, and provisions for them, however, will again differ for the various diagnostic categories, and of course for the various age-groups. So again we have to put their discussion off until later.

23. *Methods of Examination.*

After both, children and parents, have been characterized by a number of features, one will now probably ask, what services the Psychiatric Center was able to provide for them.

Unless a child was brought unexpectedly, at a busy moment, 1-1½ hours' time or even more was set aside for any first consultation. Older children and those amongst the smaller ones who were confident enough to accompany a stranger without their parents, were taken for examination by the psychiatrist, while the social worker noted the history from the accompanying family-members. This gave the doctor the advantage of observing and examining the child without being prejudiced by the parents' account of him. In other cases, the child was only seen after the history had been taken by the social worker. Some very anxious and clinging children could only be examined

in the presence of a relative. In some cases, however, the child would have been quite content to remain alone with the doctor, but the parents were so anxious and suspicious, that they insisted on accompanying the child and watching the doctor's procedure. Some parents seemed to have quite phantastic ideas about what a psychiatrist would do to their child. In more than one case we heard a father or mother ask, when the child came back from the consulting-room with the doctor : "Did he—or she—not beat you ?"

One main aim was always to make the child feel comfortable and relaxed during examination. If this could be achieved better by allowing one of the parents to stay with him, we had no objection ; but we did not encourage the presence of parents who were merely out to calm their own anxiety and to satisfy their curiosity. Observing the children together with parents or other relatives, e.g. occasionally also with siblings, either in the waiting-room, the social worker's office or even during examination, often was a very revealing experience : irritable scolding, exasperated shouting, constant admonitions, bribing by false promises, anxious clinging, eternal criticism or attempts at prompting and pushing the child into displaying his best performance for the sake of parental pride, important differences between emotional tone and verbal content of remarks meant to be reassuring, are only a few random examples of parental attitudes we were able to witness in action on such occasions. The parents, on the other hand, often got some living instruction by watching the doctor deal with their child with patience, a sense of humour and an imaginative approach. One often felt that the interest and concern, which the doctor spent even on an extremely dull or stubborn child, helped the parents to see their offspring in a different light and perhaps to discover potentialities they had neglected.

Each child was given a routine physical examination with special attention to neurological symptoms and to any signs of malformation. Very anxious children, some of whom had obviously been scared by parents' threats that the doctor would give them an injection or something worse, at times resisted physical examination violently. Wherever possible, contact between doctor and child was first established in the play-room, and the physical examination only added, in as playful a manner as possible, when the child had gained confidence.

Any child guidance clinic, even if it cannot be run as a fully psychiatric institution, should have the cooperation of a medical person, if possible a psychiatrist or a paediatrician. Leaving undiscovered such important issues as a rheumatic heart, deformed legs, a suppurating ear, massive infestation with abdominal parasites, or pathological reflexes that betray a damaged brain, can lead to serious misjudging of a case and also futile or ill-advised therapeutic measures.

For observation of the child's behaviour and assessment of his intellectual development, we relied as much as possible on spontaneous observation and on tests which were likely to appear as play rather than as a serious task to the child. In the eyes

of the clinical, and even more the experimental psychologist, our procedure may have been very "unscientific" and unlikely to yield any precise results.

The reasons why we did not invest much time and effort in systematic testing, were several : First it was a problem of time and suitable staff. As the Center was not in first line staffed and equipped for children, but for adult patients, and even for these with an accent more on treatment than purely scientific investigation, there was no scope for a full time psychologist, and, of the medical staff-members, no one could afford to spend hours on testing. The parents too, particularly the ones who came from outside Lucknow, were seldom prepared for a lengthy investigation. Our aim was to put the usually short time available to such use, that we should get as complete information as necessary for establishing diagnosis and prognosis, while, at the same time, giving child and parents the impression that we had been there for them and their benefit, and not just out to satisfy our own scientific curiosity. In systematic testing, however, relatively much time is spent in a way that gives a child (or even an adult !) the impression that he has "to do something for the examiner" (*imtehan dena*) instead of his feeling that something is being done for him. The often highly theoretically formulated results of such systematic tests furthermore seldom give the parents the satisfaction that something has been contributed towards the practical solution of their problem. Even where parents have the necessary intellectual understanding for test results, the communication of a "mental age" or "intelligence quotient", may only confirm them in their ambitious figure-mindedness, and the child may in future get his criticism, reproaches and "encouragements" served in the form of percentages or months of age by which he lags behind his age-fellows instead of simply being told that he is a "buddhu".

These few remarks should by no means be taken to suggest that tests are absolutely unnecessary or even harmful. In connection with mere questions of scholastic achievement, choice of career or line of studies and similar issues, they have their full justification. In some cases, in which the parents were ready for a thorough investigation, and in which testing was likely to help, for instance in the differentiation of a true mental deficiency from general infantilism or an emotional impairment of scholastic achievements, we ourselves referred the parents to the District Psychological Center, with whose staff-members we had some very fruitful collaboration. A skilled and experienced psychologist or psychiatrist will gradually learn to administer even a formal test in a way that will seem like play or informal conversation to a child.

Our objections only go against systematic and stereotype testing as the only means for assessing a child's abilities. Any artificiality and emotional rigidity of the situation, will certainly disturb the spontaneousness of the child's behaviour and may, as we have already hinted, put him into a situation in which *he* has to "give", instead of being able to relax in the presence of someone who "gives" *to him* time, attention and interest, without expecting any special achievement. Thus, while testing may reveal mainly defects and shortcomings, observation of spontaneous behaviour in play and in

exploring a room, may show more of the potentialities. And if, in a minimum of time, one wants to arrive at some practical and constructive advice to the parents, having observed and being able to recommend a child's perhaps still unused potentials, may benefit both, parents and child, more than just expressing in imposing figures the defect which was already known. A "heart-to-heart", common-sense talk with the parents, in which the findings of physical examination, general observation and any testing possibly done are discussed, stressing in particular any strong and promising points of the child, will often be more revealing than a mere figure. In this way, even one single interview can perhaps already achieve a modest therapeutic result, by changing the parents' attitude and rousing a new interest in them for their child.

Some of the parents, however, were quite obviously figure-and report-minded and insisted on having our observations and conclusions put down on paper. The father of a motherless boy who in his eagerness to fulfil the father's high ambitions had resorted to cheating in an exam and then, in the following depression, had attempted suicide at the age of 15, gave vent to his resentment about not having been given a written report, but "only" a thorough discussion of the boy's needs during a lengthy interview, in the following words of a letter : "You were good enough to tell me orally the psychological conflicts that had grown in him. All that you had narrated, could, of course, not be possibly memorized by me and to bring home all that amongst my friends and relations for their guidance was still more difficult.....If you had been good enough to give me your report in writing, it would have helped me to read it ten times and discuss with my friend doctors quite correctly and precisely. After doing the whole thing, you left me in blankness to ponder and speculate that you had said something like this or that or what and what not.....A thorough picture of the boy's past, present and future will remain precisely before me by your report ; otherwise a doubt will be hanging every time for what you said and what was to be done."

If a father has to learn about his boy's "past, present and future", through the report of a doctor who has seen the child perhaps for 1-2 hours, and if all he intends to do with this report is to "memorize" it and discuss it with his friends, instead of committing to his heart what was thoroughly explained to him, one need hardly wonder that, in the atmosphere of cold correctness and precision betrayed by these extracts from the letter, the motherless boy had fallen into depression and despair !

From spontaneous play with bricks, marbles, beads, the child can gradually be led to the more organized activity of arranging similar blocks according to shape and colour and possibly according to a number of holes and corresponding pegs. Drawing and painting, either on paper or on a big blackboard, is one of the situations in which a child can reveal much, without feeling that he is in a situation of formal testing. In children with motor handicaps, for instance the cramped up size and uneven flow of their lines on the blackboard often gave valuable indications about needs for loosening the limbs by physiotherapy, while in other children, the big movements, for which even a whole wall of blackboard was hardly large enough, betrayed their expansive

tendencies. Economy, fear of "spoiling" the paper, or, on the contrary, lavish smearing of one page after another, often not only showed us, what the child's own characteristic features were, but also, what parental pressure was probably exercised. Aggressive trends, or, on the other hand, anxious and timid reluctance, can come out, when the child is faced with any material that allows a more energetic procedure, as for instance shaping plasticine, playing with water or with a ball or rubber-ring in the open air.

Apart from all the material provided, however, the relationship which the child forms, or perhaps refuses to form!—with the examiner, can open up the most valuable insight into problems, but also into potentialities. The examiner has to allow himself to relax in a predominantly passive, permissive and uninterfering, but yet emotionally participating attitude. In this way, one may experience, what attitude or reaction the child, unconsciously or perhaps consciously, wants to provoke in the observer in his attempt either to constellate the accustomed home-situation or, on the contrary, to emancipate himself from it or even to rebel against it.

In older children, of course, observation at play can often be replaced by a verbal interview, for which, again, an atmosphere as relaxed and comfortable as possible has to be provided. Where spontaneous information or answers to questions do not reveal enough, projective tests, like Thematic Apperception Test (according to Murray or in one of the Indian adaptations) and Rorschach's "inkblot-test" may have their place, though not with an aim of just calculating a score, but to be used judiciously as part only of a more general assessment of the child's difficulties. Drawing of a "self-portrait" or of the persons of the family, can be particularly revealing in elder children and adolescents. Children are in general much less reluctant and self-conscious than adult patients about engaging in tasks of this kind. But even in this young generation, which finds not only more technical instruction, but also more encouragement to self-expression by drawing than older people did, one often finds rigid clinging to a few stereotyped, traditional patterns. We shall have occasion to describe and discuss some of the drawings, when we deal with the individual functional groups.

As we have already mentioned, discussion of all the findings with the parents forms an important part of the first consultation. Possible causes of the child's difficulty have to be explained in terms which a layman can readily grasp. Physical defects may have to be pointed out and further investigation, e.g. by laboratory tests, X-ray or even electro-encephalogram, suggested for them. For any drug treatment, careful instructions have to be given. The most delicate task, however, is to show the parents, in which way their own attitude may be at least partly responsible for the child's trouble and how they themselves can contribute to the child's harmonious growth. Though at times it may be difficult to hold back one's indignation about the gross carelessness, ignorance, selfishness or even cruelty one has noted in the parents' behaviour, one has to abstain from sharp criticism, as this might only put the parents up against any positive advice and thus would hardly benefit the child. One has, on the contrary, to try

one's best to appreciate the parents' difficulties and any honest, though perhaps awkward, attempts they may have made to solve them. Parents' inability to give shelter and love to their children often proceeds from the lack of security and true affection to which they themselves are exposed. If they feel rejected by the doctor's or social worker's critical or moralizing attitude, they may perhaps grasp a few points intellectually, but they will certainly not make any gain in warmth and stability of emotions, which they might hand on to the child.

As already hinted, the psychiatrist's interest in the little patient, his ability to discover potentialities and to find amiable traits even in a child who has come to be regarded as a mere nuisance or monster, can greatly revive and stimulate the parents' interest. On the other hand, however, if perhaps one manages to gain the affection of a child who remains indifferent, closed up or sulky with regard to the parents, one also has to guard against the parents' jealousy, which again would create a poor ground for the acceptance of any advice.

A hard and bitter duty is often to explain to still hopeful or even overambitious parents that a mentally deficient, epileptic or paralysed child has no hope of being definitely "cured". Many parents have already been dragging a poor child of this kind from doctor to quack and from quack to fakir, in the vain hope that someone, after all, might perform the miracle. As far as we have been able to observe, there are enough people ready to profit by such credulity. Others again, who are consulted, may not take enough time to explain to parents all the implications of the illness and the possibilities for treatment, or possibly they may not have sufficient courage to tell the truth about an incurable condition.

Even a disappointing statement of the truth, however, can often be accepted surprisingly well, if it is at the same time coupled with suggestions for developing to the best, whatever abilities and potentials may be left in the child. Furthermore, the parents can be given an opportunity to ventilate their secret thoughts and feelings about the child's trouble and perhaps even helped to see their personal misfortune in a wider philosophical or religious context, e.g. as a God-sent opportunity for developing and practicing certain virtues.

Much of what has been mentioned now, should perhaps already belong to the phase of treatment, which we are going to discuss next, at least to that part of it which we might call "parent guidance". One certainly may have a better chance of influencing the parents' attitude, if one can gradually build up a friendly and confidential relationship over a long period. All too often, however, a single consultation was the only chance we got, particularly when children were brought from far away. So we had to try to make the best of what little time was available and often perhaps reveal with rather too much abruptness truths that might have been borne better by a slower procedure.

24. *Possibilities of Treatment.*

Possibilities of rendering help to the children examined, were in first line limited by the fact, already mentioned in the Introduction, that less than half of the patients were brought back for more than one visit, and only 27.4 per cent for more than 2 visits. Apart from this, a fundamental obstacle against efficient therapeutic measures often lies in the nature of the psychiatric disorder itself. In congenital and organic conditions, prospects of changing the child's state decisively, are obviously less bright than in a merely functional disorder. The graphs (Graph VIII and IX) will therefore be given separately for the congenital-organic and for the functional group. From these, one will see that, in the functional group, the pyramid, with the great number of children who only came for one consultation as its base, rises fairly steadily and evenly to the upper regions, where prolonged treatment is represented, and that it even broadens out slightly on the level for "more than 10 consultations" and "in-patient treatment". Against this, the graph for the congenital-organic group, rather reminds one of a long battleship with a slender mast and a few flags and look-outs sticking out from it. This difference in the shape of the graphs holds good, not only in those for all congenital-organic and functional conditions taken together, but, to a certain degree, also for the individual diagnostic groups.

One may be rather surprised to observe that, amongst the girls, the proportion of patients brought for repeated visits, almost throughout the various groups, is rather more favourable than that for the boys. This again is a peculiarity which we had already signalled in the paper written in February 1959 [Hoch (16)]. At that time, we commented on it as follows: "Parents of girls seem to be in general more determined than those of boys to get actual treatment, once they have made up their minds to do something for their daughters. Amongst the boys, 70.2 per cent of the cases were only brought for one consultation and then dropped out. This happened in only 53 per cent of the girls. Though only one girl could be won for regular psychotherapy over a prolonged period, while 5 boys were given this benefit, more girls than boys were brought back for 3 or more consultations of a not specifically psychotherapeutic nature."

Almost 3 years of further experience, as will be seen from the graphs (Graph VIII and IX), do not seem to have changed this ratio very significantly. This relative predominance of girls amongst the children who were brought for repeated visits, may seem all the more strange, if we remember that boys have been considered worth consultation far more frequently than girls. Ultimately, however, these two phenomena may perhaps not so much contradict each other as far more confirm the same underlying attitude: After pointing out that girls, even if they suffer from congenital defects, often are only brought for examination, when they reach adolescence, we noted in the 1959 paper (16): "The determination of getting an adolescent girl into fit shape for marriage, may also be one of the factors that affect the persistence with which the patient is brought for treatment." A boy who can be kept for "home-use", may be tolerated

as he is and, if any proposition other than an instantaneous magic cure seems too cumbersome and awkward, the urgency with which this meagre chance is seized need not be all too great. One may still resort to such methods later, when all hopes for a magic cure have been exhausted. For a girl, however, the approach of a marriageable age sets a sharp time-limit, before which, at all costs, she has to be rendered—fit, if not for marriage itself, then at least for the potential in-laws' scrutinizing gaze. This may increase the readiness to bring a girl even for what may seem a doubtful, expensive and time-consuming attempt at treatment. Furthermore, as we know, 4 of the psychotic girls were already married, and the husbands and in-laws, with whom they were to spend the rest of their lives, or the parents to whom one of them had been returned, had every reason to seek treatment ! Again it seems that the relatives' willingness for consultation and treatment cannot always be regarded as purely seeking the benefit of the child as such, but that it is rather directed towards the "use" they want to make of the child.

That the parents of the children who persisted in treatment in spite of the often slight hopes and assurances we could give them, were at least partly rewarded, is shown by the graphs (Graph IX) illustrating the results of therapeutic efforts, which, for easy comparison, we have placed just underneath those for the number of consultations. One will have to note that the basic column of these graphs, labelled "not returned" does not only include children who did not return after the first visit, but also all those who dropped out after 2 or more visits, but before the result of any treatment advised or actually started could be properly assessed. This column is therefore in most cases longer than the one for "one consultation" in the other graphs. On the other hand, even some of the patients in the column for "one consultation" in the first series of graphs, may possibly be represented in the categories of "slightly improved" or "improved", when we were informed about the results of our therapeutic advice by letter or casual visits of a relative, as it happened in quite a few cases that had been brought from far away. The column "not improved", only contains children in whom, after an honest attempt at following whatever advice we were able to give, return visits or possibly correspondence gave no indication of a change for the better. This does not exclude that, with the necessary persistence, a result might have been reached. Some children of course were so severely handicapped since birth, that no noticeable improvement could be expected by any method.

It would, however, be a sign of foolish vanity, if we were to regard the correspondence between the figures for cases brought for several consultations and those for successful treatment, which our 2 series of graphs seem to render obvious, exclusively as a proof for the effectiveness of our treatment. The correlation can just as well be formulated the other way round, i.e. not : "Whoever persisted in treatment, got rewarded by improvement", but much rather : "whoever was given some legitimate hope of profiting, took the trouble to come back." This plain truth reminds one of the practice of the ancient Indian physicians, who apparently were only willing to accept the responsibility for treating a case, after they had made sure that the patient's vitality

and life-expectation, which they estimated from subtle signs, was likely to assist them in their efforts ! Our approach may not have been quite as explicit as this ; but, no doubt, the cautious way in which we formulated our prognosis and the slender hopes for any possible improvement, may have suggested to many parents that we were none too keen on taking up a case which apparently we regarded as hopeless.

The author has since, in a more generally medical activity in a hill-area, had occasion to realize, how far the ideas and expectations which patients and their relatives entertain with regard to doctors, are still coloured by magic concepts. If the doctor does not immediately prescribe or even give a drug, as a concrete vehicle of his magic power, this may be interpreted as signifying his inability or his unwillingness to undertake any thing in the case concerned, no matter, how much "non-material" advice, concern and reassurance may be given. In one case of a very severely dystrophic child, for whom the proper medicines and special foods were not "in stock" for immediate free distribution, even the author's sincerely offered promise to get the necessary preparations from the nearest town within a day or two, were obviously just regarded as a polite covering for an implicit admission of the doctor's helplessness or lack of interest in the case. The drugs were duly procured the next day ; but no one ever came back to fetch them !

This little experience, though not from the special field of psychiatry, illustrates, how important it may be to have something concrete to give to patients and their relatives. Even the rather abstract bit of paper of a prescription may not have quite as much magic property as a drug taken direct from the doctor's hand or possibly even prepared by him.

The inability to substantiate their attempts at help by administration of drugs, is a problem that vexes those who are in charge of child guidance clinics run by non-medical staff, i.e. psychologists and social workers. A drug is not only a concrete sign of the doctor's concern and hopefulness with regard to the case, but, particularly if new supplies have to be fetched from time to time, or even only reports given about the effect, it also assures to a certain extent possibilities for prolonged treatment and follow-up information. Even if the main method of treatment should consist in guiding the parents, their coming for a regular supply of drugs will give an opportunity of talking to them, which otherwise one might not find. Such persistence, however cannot even be achieved by merely writing a prescription, but only by dispensing the drugs, if possible free of charge or at a self-cost price lower than that of the chemists' shop.

One need not even resort to an inactive placebo in order to secure the parents' continued interest. Nowadays one has a great choice of drugs : tonics, stimulants, sedatives, tranquilizers, anticonvulsants, which, though they cannot "cure" a basic condition like oligophrenia or epilepsy, can at least give some relief, e.g. by stimulating a dull child, by calming an all too restless and mischievous one and by

reducing or completely suppressing convulsive fits. Any little improvement, however symptomatic and perhaps temporary it may be, will strengthen the parents' faith in the doctor and prepare the ground for dealing with their faulty attitudes. If, by this method, repeated visits can be kept up, the parents may be influenced quite imperceptibly and, rather than having to admit that some of their difficulties with the child were due to their own mistakes, they can save their pride by ultimately giving credit to the drug for any improvement that may really have been brought about by their change of attitude.

Each diagnostic category, of course, asks for its own remedies. Drug treatment and any other specialized therapeutic procedures, such as play—therapy, psychotherapy, parent guidance or even in-patient treatment for adolescents above the age of 14, can therefore only be dealt with in the chapters on individual groups. There, the further implications of the graphs illustrating number of consultation and results can also be better appreciated than this is possible in this connection.

We might, however, at this point, take a look at the figures for "results" summed up for the congenital-organic and the functional group (Graph IX). The percentages for all degrees of improvement in the functional group, with 37.9 per cent, is almost exactly twice as high as that for the congenital-organic group. For the girls in the functional group, we get the remarkable rate of 55.5 per cent of improvements, while for the boys the figure is only 25.5 per cent. As, theoretically at least, hopes of improvement can always be given in functional cases, this difference in the figures for girls and boys can probably be attributed to the fact that the parents of girls gave us more chances of seeing their children repeatedly than those of the boys. In the congenital-organic groups, the difference with 28.1 per cent improvements in girls and 16.8 per cent in boys is not quite so marked, but still perceptible.

While grown-up patients, even if first they are brought by relatives, can make treatment their own concern, once they have confidence in the psychiatrist, children depend on the parents' willingness, not only for paying the fees, but also for allowing them to go to the Center either alone or with an escort. We have seen quite a number of children who would have been only too glad to come regularly for play-therapy or "talks", or who even made stubborn scenes when, at the end of a consultation, they were supposed to leave. One little boy, who perhaps established a record by coming for 37 visits distributed over more than a year, was so eager to come, that he even took the risk of having to wait, sometimes for more than an hour, until someone fetched him back, when the therapeutic session was over. The same boy once expressed his anxiety and despair in a weeping voice on the telephone, when, due to a misunderstanding about a "bill", which was merely a statement for "free service", his parents told him that further visits would be too expensive. While this boy, at the age of 10, was old enough to learn coming on his own, other children, who remain tied, not only to the father's purse strings, but also to an anxious mother's apron-strings, may not be fortunate enough to continue on their own a treatment which they themselves have recognized as beneficial.

As we pointed out in the chapter on "local origin", the long distances from which more than half of the children were brought, probably played an essential role in reducing the number of return visits and regular, prolonged courses of treatment. This difficulty can only be solved by multiplying psychiatric services for children and possibly creating mobile units. While many of the parents coming from outside Lucknow certainly never had considered more than one consultation, just to get "the foreign doctor's opinion", others might have been glad to let the child benefit by repeated visits. In still other cases, any real help would have had to consist in schooling at a special institution or even in residential treatment, away from the harmful influences of faulty parental attitudes.

Facilities of this kind, however, are still very rare here in India. An extensive programme of developing the needed services may therefore have to be undertaken in the near future : building up decentralized or mobile psychiatric clinics, special schools for mentally deficient and possibly also for emotionally maladjusted children, residential homes for observation and treatment of all types of mentally and emotionally disturbed children, and occupational therapy—and vocational training-centres for mentally handicapped adolescents.

One of the main problems may consist in securing suitable personnel. As yet, there is hardly any possibility for training specialized workers in these fields here in India. Young Indians : psychiatrists, psychologists, social workers, trained abroad, often come back with notions that cannot be adapted to the needs of the Indian public without a quite conscious and deliberate effort at "re-orientation". If, on returning to their homeland, such specialists find conditions less advanced and refined and prospects of financial remuneration and professional recognition less tempting than abroad, they may shrink back from a pioneering venture and prefer to return to well-established services in the West. Looking after mentally handicapped and emotionally disturbed children, is a task that cannot be accomplished merely with an interest in scientific theories and perhaps an ambition for "shining" in a new field ; it asks for infinite patience, loving concern, emotional stability and maturity and an ability to sacrifice one's own comfort to hard work which may be rewarded by very little spectacular success. To find people of this type and to give them the right kind of training, which keeps account of the particular needs and problems of Indian children, may be more difficult than any question of raising funds and constructing buildings.

Another problem will be to educate the public to a proper understanding and use of existing or proposed facilities. Not only parents, but all those who are in a position to observe children's deviant behaviour, as e.g. teachers, doctors, youth-workers, police-men, probation officers, staff of hostels, orphanages and children's homes, have to be enlightened about the needs and possibilities for investigation and treatment. This can partly be done by literature : books, pamphlets, articles in journals and newspapers, partly by lectures and discussion groups, e.g. within the frame-work of child welfare organisations and parent-teacher associations.

The objection that, before all this can be undertaken, a "survey" will have to prove and estimate the needs, has been dealt with earlier. It is hoped that already this first part of an analysis of experience made "in action", may have brought some conviction that research as true "re-search" can produce its results in the form of figures, graphs and detailed observations in addition to relieving, though perhaps to a very modest degree, the suffering of children and correcting some wrong notions and attitudes in their parents.

CHAPTER III

The Individual Diagnostic Groups

1. Synopsis.

In the preceding chapters, our observations have been communicated as far as they have some relevance for the total group of children examined. This was, however, not possible without already pointing out the variations in the individual diagnostic groups and, in particular, the differences between what we summed up as the "congenital-organic group" on one hand, and the "functional group" on the other hand.

Before we now examine all diagnostic groups in detail, it may be profitable to sum up the data mentioned in the various chapters of Part II, in a kind of synoptic table, in which the salient features of each group are to be rendered prominent. (See Table XVIII and XVIIIa).

These synoptic tables will help us to characterize and sum up each diagnostic group and at the same time provide a kind of index for the peculiar features to be discussed.

2. Oligophrenia.

(a) *Definition and Differential Diagnosis.*

The term "oligophrenic", taken from Greek, signifies a person who has "little brain" or who, if we consider brain and mind as in a certain sense identical, is "mentally deficient." Already earlier, we have pointed out that mental deficiency in the strictest sense only designates a lack of potential for intellectual development which exists right from birth. As, however, the result of a loss of initially present intellectual potential through very early postnatal damage, though strictly theoretically a "dementia", amounts practically to the same as a congenital mental defect, such cases are often included in the diagnostic category of "oligophrenia". One will see, from examples to be given later, that amongst our cases there are some in which it may be difficult to state, whether a defect was already present at birth or caused by a difficult delivery or possibly only due to some postnatal influence. In general, we have placed those cases, in which an initially normal development was decisively arrested or deflected by a dramatic happening, as e.g. high fever, convulsions in early infancy or childhood, into the

group of "postencephalitic" children. This may be against the usage of certain textbooks ; but one will see that the cases assembled in the "postencephalitic" group have their characteristic features and that, not only with regard to hereditary risks for further children in the family, but also from the point of view of preventive measures and possibly treatment one may do well to distinguish them.

Another delimitation which we tried to make, was against what we have kept apart as the small group of "infantilism", or more comprehensively : "Psychophysical infantilism", into which we have placed a few children whose mental retardation only formed part of a quite general slowing up of physical, mental and emotional development. These cases are characterized less by lack of potential for intellectual development, but rather by an inhibition of the speed with which this potential matures into actualizing itself.

Epileptic fits occur in quite a number of children whom we have classified as oligophrenics, probably as a symptom of the same brain defect which is responsible for the intellectual weakness. The epileptic group in a strict sense contains only those children in whom convulsions and possibly mental deterioration manifested themselves on the basis of an initially normal intellectual development. In some cases, the differentiation may not have been quite plain and easy.

The distinction between genuine mental deficiency, particularly in its milder forms, and states in which intellectual functioning is impaired by emotional factors, is easy, when the neurotic deviation has only set in after an initially normal development. If, however, the emotional distortion is present right from infancy, as e.g. in the group which we have termed "infantile psychosis", close observation may be necessary to decide the issue. In general, one will find that, either under spontaneous observation or in a test situation, such children will suddenly betray their superior abilities by doing well in a task far beyond the level of other performances that seem to determine their general standard ; in other words : their test results show the phenomenon of scattering.

Adolescent psychosis, finally, may have to be differentiated against more temporary states of excitement or possibly confusion, which one frequently finds in oligophrenics, e.g. if they find themselves in unaccustomed situations.

Within the group defined by all these differential-diagnostic considerations we again have to distinguish various forms of oligophrenia : on one hand according to the grade of the defect, on the other hand according to its probable origin.

In general, one distinguishes 3 grades of mental deficiency. In idiocy, the most severe form, the child is incapable of growing beyond the stage of mere instincts. Sometimes not even these are properly developed. Very seriously handicapped children will not even know, how to announce their bodily needs and will expose themselves to any danger without learning from experience. Such children will have to be taken

care of all their lives, as they cannot survive on their own. It looks, as if even certain biological defence patterns were insufficiently developed : often such children fall a victim to some infection, before they have reached adult or even adolescent age.

Imbecility, a slightly less severe form of mental deficiency, still allows the child to form certain conditioned reflexes, to learn, by simple training and routinizing, just enough to be able to take care of his most primitive vital needs. Under good care and training, such children sometimes can even be taught to perform some simple manual work.

The moron's intelligence goes a little beyond this stage ; but his insight and reflection, his ability to adapt to new situations, in particular also his capacity for abstract thinking, is extremely limited. A still milder form of mental deficiency is what we call "mental dullness". This is actually just the minus variant of the normal distribution curve of intelligence amongst a population. People of this kind can function quite adequately in life, if they are allowed to remain in a sheltered position, in which demands on their powers of adaptation are not too high. [See also Hoch (17)].

In our material, we find the following distribution of children amongst the 3 main grades :

TABLE I*

Distribution of oligophrenic children amongst the 3 grades of deficiency

	Boys	Girls	Total	Ratio of boys to girls
Moron	15	2	17	7.5 : 1
Imbecile	23	9	32	2.5 : 1
Idiot	10	5	15	2 :

* The small tables for the individual diagnostic categories, in contrast to those concerning all groups, are to be given in the text and are numbered separately with Arabic figures ; similarly the graphs to follow.

One will note that imbeciles are most frequent in our material. This may signify that parents of children with this medium degree of disability may still entertain hopes, while parents of idiots, if the children survive at all, may have realized the hopelessness of the condition. Children with milder forms of oligophrenia, on the other hand, particularly in surroundings with little intellectual aspirations, may pass unnoticed or be tolerated as still within normal limits. In fact, most of the children who were classified as "moron", were brought, when the basic mental deficiency had already been complicated by a neurotic superstructure.

If we want to present examples of the 3 groups, it is therefore not quite easy to find a pure case of the mildest degree. The only case which was left in the "pure group" after elimination of all functional complications, may possibly, according to a stricter standard, already have crossed the lower limit of what one would like to term as "moron".

- (1) *Rani*, aged 8, was brought by her elder brother from a small country-town in U. P. He described her as mentally backward, unable to speak properly, destructive, obstinate, uninhibited with strangers. She could control neither her appetite nor her toilet needs. Like a small child, she tested everything by putting it into her mouth.

She was the youngest and the only girl amongst 8 children of the third wife of an already elderly Hindu lawyer, who suffered from diabetes and high blood-pressure. No mental illness had been signalled in the family. But 4 siblings, amongst them *Rani's* twin-brother, had died in infancy, so that between her and the next elder brother, there was a gap of 11 years.

Rani herself was weak after birth, suffered from frequent digestive troubles in infancy and developed very slowly.

On examination, we found a slightly cleft palate, an abnormal appendage on one earlobe, some bone deformations possibly due to rickets, and plantar reflexes which indicated a damaged or at least highly immature central nervous system. The child, whom we only saw for one visit, showed extreme restlessness and lack of concentration. Her speech was indistinct and babyish. She could carry out simple commands, but was unable to use any test material for anything else but random, unorganized play. When given a doll, she showed her understanding of the situation by slapping and kissing it.

If we had had an opportunity for observing the girl more closely, we might have decided more definitely, whether in this case too, the basic defect had perhaps already been accentuated by some functional superstructure. As the child was the youngest and the only girl of a woman with a sick, elderly husband and who had lost half of her children through early death, it is quite possible that a certain amount of pampering and maternal clinging may have kept her in a more babyish and uninhibited state than what would have been due to the basic disorder itself. As the mother did not come with the child herself, we neither could get the child's early history from her, nor observe her attitude towards the patient.

Amongst the imbeciles, we have a greater choice of straightforward cases without any complications :

- (2) *Aslam*, a 5½ year old Muslim boy, was the second child and eldest son of a cousin-marriage. After delivery of the eldest daughter, the mother

had 2 abortions. During pregnancy with the patient, she had to undergo appendectomy. His delivery, however, was normal. He was breastfed up to the age of 5 months. At the age of 5 months, he suffered from diphtheria. He only started sitting at the age of 1 year, standing after he had completed his second year and walking at 3. His younger brother, aged 4, also was retarded in his development and had not learned to speak yet.

On examination, we found signs of degeneration and of organic damage to the central nervous system : Excessive salivation, strabismus (Squinting), genua valga, oddly shaped skull with high palate, deformed feet, rather rigid arms, while the legs were slack and responded abnormally to reflex stimulation. The child was restless, put everything into his mouth or tore it up. He could understand simple commands and indicate his needs by gestures, but had not learned to speak, except for a few inarticulate sounds. In spite of this extreme impairment of intellectual function, the parents had already engaged a tutor for him !

In this case, particularly in view of the fact that the younger brother also was mentally defective, and that his birth was preceded by an abortion, the close relationship between the parents (first cousins) may have led to some genetic deterioration.

Examples for idiocy are numerous in the "pure" group, as combinations with functional disorders are not likely to occur in these extreme states.

- (3) *Pushpa*, for instance, even at the age of 14, had not learned to speak yet. She was restless and easily frightened. She could indicate her needs by gestures and obey some simple commands.

The skull was abnormally small (microcephalic) and some parts of it sounded hollow on percussion. The front-teeth were small, peg-shaped. One ear-lobe had an abnormal appendage. The spine showed an exaggerated dorsal kyphosis. She walked in a plump, awkward manner, on a broad base. She could hardly speak a few words and all she knew to do with toys and other objects was to throw them about.

No case of any psychiatric illness was signalled in the family. The girl was the third of 5 children, of whom one had died in infancy. The two brothers, younger than her, were rather behind their age in school. Two pregnancies of the mother had ended in abortion.

Pushpa was born on term and without complications. Breastfeeding was continued up to the age of 12 months. She learned to sit at the age of 1, to stand at 2, and to walk at 4. She was treated for infantile liver cirrhosis at 2 and had small-pox at 7. At the age of 13 she started menstruation. Both parents were a bit anxious and overconcerned ; but their attitude had hardly had a chance of affecting this microcephalic idiot.

It is perhaps not quite by chance that all the 3 specimen cases we have presented, are characterized by restless behaviour rather than by dullness and inertia. The erethic imbecile and idiot can be far more of a behaviour problem for the parents than a dull, apathic child, who can often be managed and even trained to some routine fairly well. There is therefore presumably more chance that children of the former category will be brought for consultation.

In most of the tables which are to follow, the figures will be given separately for the three grades of mental deficiency.

(b) *Causes and origin.*

Distinction of origin of the disturbances, as far as this is possible, can provide us with a second system of classification. In general, one finds the hereditary forms of oligophrenia amongst the milder degrees, while the severe forms are more likely to be due to intrauterine damage or to birth injury. One reason for this may be that seriously handicapped mental defectives do not come into a position to get married : either they die before they have reached maturity, or they are so obviously incapable of managing life, that usually no one would think of burdening them with the responsibility for a family. Under the joint family system, even this seems to be possible. In general, however, one can reasonably expect that very severely mentally deficient persons will not reproduce and therefore, even if their illness should have a hereditary component, they would be prevented from transmitting it to any offspring. But one knows that many of the most serious forms of oligophrenia are not hereditary and not even constitutional in the strict sense, but very often the consequence of some brain damage which can be prenatal, early postnatal or sustained during the delivery itself. The causes can be malformations due to some local uterine factor, maternal syphilis, maternal virus disease, in particular maternal rubella during pregnancy, birth trauma, asphyxia, encephalitis or meningitis in very early infancy.

In our material, intrauterine damage was rendered reasonably probable by some evidence of disturbed pregnancy or the particular dysplastic and organic signs in the child, in 8 cases, half of them amongst the imbeciles, while birth injury could be assumed as the main cause in 5 cases, 3 of them counted amongst the group of morons, 2 amongst the imbeciles. In the remaining 51 cases, there were no definite indications or no sufficient information that allowed to place the origin of the impairment at a definite stage of development.

This is in particular also valid for the group of children whose parents were known to have suffered from syphilis. One assumes that in certain cases the disease can affect the germinal cells themselves, while in others the embryo is exposed to intrauterine infection, when the mother suffers from an active stage of the disease. In 10 of our cases of oligophrenia, at least one of the parents or both were known to have contracted syphilis themselves or to present physical signs of congenital syphilis which they had already taken over from a former generation.

A particularly instructive example of the way in which congenital syphilis can ruin the health of a whole family, is the following :

- (4) *Shankar*, a Hindu boy of 9, whom we classified as imbecile, was found to have a strongly positive Wassermann and Kahn reaction in the blood. The father, a lawyer from Eastern U.P., maintained that he knew of no syphilitic infection. He had a brother who was an idiot. The mother, disfigured by slight hunchback, looked older than her age and was mentally dull. Of her 9 pregnancies (at the time when we first saw her, she had started the 10th !), 3 had ended in abortion. The first two children died in infancy. The eldest living child, a daughter aged 18, was later examined by us because of epileptic fits, occurring since the age of 9. Her Wassermann reaction happened to be negative. The next child, 9 years younger, is our patient *Shankar*. A younger brother, aged 7, was also examined by us. His mental deficiency, also of the grade of imbecility, was complicated by epileptic fits and paralysis of the right arm since the age of 4. His blood test also gave a negative result, which may, however, have been due to a recent attack of high fever. The only other surviving child, a girl, looked mentally dull and uninhibited, but was regarded as "normal" by the parents. Her serum reactions were strongly positive !

While, in this family, syphilis may possibly already have been handed down by former generations, the parents of a next case seem to have contracted the disease in their own lifetime :

- (5) *Sharda Devi* was brought at the age of 7. Her mother had been given some injections during pregnancy "for some blood disease", presumably because previous pregnancies had resulted in abortions and 2 children had died in infancy of liver trouble, while only the eldest child, born 7 years before our patient, had survived. 4 children younger than *Sharda*, probably born after both parents had been thoroughly treated, had not shown any signs of physical or mental defects at the time when we got the family history. In *Sharda* herself, apart from her imbecility, of erethic type, we noted a small skull, deformed feet and asymmetric reflexes.

Thus, with regard to syphilis, unless we find definite degenerative signs (e.g. the typical deformed teeth) in the parents or, on the other hand, a clear history of maternal syphilis in an active stage at the time of pregnancy, we may not be able to draw an exact distinction between strictly hereditary and merely congenital forms of the disease.

We have already pointed out earlier that, quite generally, our information about heredity may not have been as accurate as one might have wished it to be. Milder forms of oligophrenia, about which nowadays, in the age of literacy and higher education, parents are getting worried, may have passed unnoticed or at least have been tolerated in previous generations of the same family.

One case, in which we can be fairly sure of a gross influence of heredity, and which, contrary to expectation, presents a very severe form of mental deficiency, on the borderline from imbecility to idiocy, is the one Anglo-Indian boy in this group :

- (6) *John*, aged 6, but very tall and sturdy for his age, fair-haired and pink-skinned, was brought for consultation by his middle-aged foster-mother, who had obviously taken great care to train the boy to some order and discipline. After some hesitation, she told us that the boy's parents, both mentally dull, were brother and sister, coming from a family in which several people had hunchbacks and other malformations. The incestuous relationship between the two young people apparently took place, when they met each other during a holiday at the place of their foster-mother, the same woman who later brought up John, the result of this unfortunate union.

A case in which we can assume intra-uterine damage with a good amount of certainty, is the following :

- (7) *Ashok*, aged 10, was the 8th of 10 children of a Hindu railway official. Both parents were nervous and emotionally unstable. The father suspected that he "might have had syphilis", but was not sure. The more relevant fact, however, was that, except for the first and the 10th child, the mother, who resented having too many children, attempted abortion during every pregnancy. We do not know, what means she resorted to when carrying the other children, who seemed to be normal. When pregnant with Ashok, she submitted to no less than 4 attempts at abortion by a "dai", but without success. The delivery was complicated and the child developed slowly.

On examination, we noted dysplastic features and signs of organic brain damage. It is highly probable that the massive disturbances during embryonal life impaired the growth of the central nervous system. Added to the congenital mental and physical defects, was a distorted emotional development, which need not surprise us in view of the careless or even rejecting attitude of the mother with regard to all of her children.

As a typical case of birth injury, we can quote :

- (8) *Kishore*, aged 14. He was the eldest child of a highly placed Brahmin family. Except for slight deafness of the mother, no illness in the family made one suspect that there might be any hereditary deterioration. We know, however, that the delivery was difficult. An attempt with forceps failed, and the doctor had already given up the case and inserted instruments meant to perforate the child's skull, when at last manual extraction proved possible after all. The child was first considered as dead and carelessly put aside. Against all expectations, he showed signs of life and survived in spite of injuries caused to face and skull by the instruments. At the age of 14, the boy had not learned to speak clearly.

He had no proper concepts of numbers even up to 5, hardly knew what to do with toys. Attempts at sending him to school and at hammering some knowledge into him through a tutor had left little impression on him. The boy seemed to be even too severely limited in his grasp of the world to have suffered significantly from the ambitious expectations and demands of his parents, unless of course a certain inhibition and anxiety may have been the result of this lack of shelter and understanding.

Since facilities for institutional treatment of mentally deficient children gave better opportunities for observing them, medical science in the West has gradually succeeded in distinguishing certain particular forms of oligophrenia more accurately than just by the 2 systems of classification just presented. The first special type to be set apart was mongoloid idiocy, which derives its name from the peculiar configuration of the face, particularly of the eyes with their "epicanthus" (the upper lidfold covering the lower one at the nasal angle) which resembles the slit-eyed features of Mongolian races. This special form of mental deficiency is supposed to be due to some intrauterine damage, though a hereditary influence cannot be quite excluded. Investigations in recent years have revealed that the cells of mongoloid children contain an extra chromosome; the 21st pair is increased to a set of three. These abnormal genetic findings, however, cannot be strictly attributed to any form of "heredity", but appear to be the result of so-called "mutation", i.e. a freakish aberration in development, possibly due to unfavourable intrauterine conditions. Some authors stress that it occurs more frequently in mothers who are advanced in age or who have already given birth to many other children.

Amongst our patients, we found 4 cases of mongoloid idiocy. As this particular form of defective development has recently received increased attention in various publications, and as material about it is also being gathered here in India, it may be of interest to give a short summary of our case-histories :

- (9) *Malti Lal*, aged 14, a Hindu boy from Lucknow, was born as the second of 8 children, when his mother was aged 16. His 3 brothers and 4 sisters, though some of them of rather asthenic constitution, were all living and had developed normally. At an early age, the boy was adopted by his maternal grandmother who had lost several of her own children. With her, he probably got more care and concern than he might have received at home amongst his numerous siblings. She brought him to India from Pakistan on partition.

Though one knows that mongoloid idiots often have very little resistance against infectious diseases, he survived a period of high fever, probably typhoid, at the age of 6 months and various intestinal upsets in later childhood. He learned to stand at the age of one year and walked at 15 months. At 3, he was able to pronounce a few words, but even at 14, he mainly indicated his needs by gestures.

Physical examination revealed most of the typical signs : nasal epicanthus, abnormally shaped teeth, hypotonic muscles and joints, rather small head. The

boy was lively, inquisitive, affectionate and, according to his grandmother and also to our own observation, particularly attracted by music, all features which one frequently finds in mongoloid children. When faced with test material, he showed some ability to sort out colours. He would, however, only persist in any systematic activity, as long as it was easy.

- (10) *Neerja*, a Hindu girl, was brought by her mother from one of the big towns of UP at the age of 15. She too presented the typical features of mongoloid idiocy: plump-body with coarsely shaped hands and feet, small, flat-backed skull, hoarse voice, slightly furrowed tongue, peg-shaped teeth, loose tonus of the limbs. Her speech was badly articulated and mainly consisting of disconnected monosyllabic words.

During pregnancy, the mother, aged 41 (the only example of an "old" mother in our material !), suffered from anaemia. Of 6 elder siblings, 2 brothers had died in infancy, 2 sisters at adolescent age. No mental illness was signalled in the family. The child, weak as a baby and subject to frequent fevers, learned to walk at the age of $2\frac{1}{2}$, but never mastered speech beyond a few syllables. The only thing she could be taught by persistent routinizing, was to change her clothes and to eat her food more or less tidily. At 13, she started menstruating and, since then, had given some additional trouble during her menstrual periods, when, without any sense of shame, she refused to take care of cleanliness and often went into spells of moody, irritable and stubborn behaviour.

We got the impression that this youngest child of elderly parents, deprived of some of their other children, was somewhat crushed by the mother's over-anxiousness. Watching her at play in the mother's presence, one could observe that often she quite obviously knew how to use the material skilfully and with understanding; but in order to spite the mother's ambitious prompting and urging, she would deliberately engage in a wrong course. She was obviously seeking for some scope for self-expression and resented any instruction, even in our occupational therapy department, which she visited for some time.

- (11) *Shant*, a Christian boy of 9, from the Southern part of UP, again presented the typical signs: slanting eyes with epicanthus, flat nose, furrowed tongue, slack tonus, hyperextensible limbs, small hands with short fingers. He could only pronounce monosyllables. At the time we examined him, he had not learned to take care of his needs and to control his excretory functions. At times he was destructive.

He was the eldest and only son amongst 2 children of a clerk. At his birth, the mother was aged 31 (i.e. not old absolutely, but none too young for a first delivery). No other cases of mental disturbance were known of in the family.

The boy was born prematurely during the 8th month. He was too weak to suck the breast and had to be fed forcibly during the first 2 days. He learned to walk

at 3 and made some rudimentary attempts at speaking since the age of 4. Several times he had suffered from fevers, amongst them typhoid and malaria. Some doctor, apparently assuming a hormonal disturbance, had prescribed thyroid extract, but without success.

The parents, both very accepting and understanding, had had the good sense to direct any efforts at teaching the boy in first line to such every day performances as locking and unlocking a door, managing his own clothes. One felt that this child had been allowed to develop according to his limited possibilities, without excessive pushing and pampering.

- (12) *Laxman*, aged 7, a Brahmin boy, had recently moved to Lucknow from a city in the South, where he had already been under psychiatric observation and treatment. He was born one year after the death of an elder brother at the age of 2, when his mother was aged 23. Again there was no record of any psychiatric disturbance in the family. 2 younger brothers were developing normally. The parents, mother overanxious, father impatient and expecting too much, were worried about the boy's retarded development, his lack of understanding, his inability to speak and his restless, stubborn, noisy and often destructive behaviour. He had started sitting at 18 months, walking at 4 years, and uttering some syllables at the age of 7.

The small, sturdy boy again presented the typical small, flat-backed skull, the epicanthus, hoarse voice, rather clumsy movements. His attempts at speech only resulted in inarticulate grunting sounds, like those of an angry animal. In the play-room, he proved to be quite lively and inquisitive. When given a chalk, he even climbed up on a chair so as to draw his lines right up to the top of the blackboard-wall.

One will note that, in all 4 cases, no "psychiatric heredity" had been signalled and that no other siblings were affected by any similar anomaly. None of the parents were consanguineous. Only one mother had been "old" at birth of the child (*Neerja* 10), who was the youngest of 7. If one can dare to present any percentages for so small a number of cases, this would amount to a rate of 25 per cent of "old mothers", aged above 35, while for our total material the figure is 6.3 per cent, for oligophrenia 5.3 per cent and for the mothers admitted at Queen Mary's Hospital in Lucknow, 7.3 per cent.

Two of the 3 boys are second in the sibling-row, one however the eldest surviving one, while one is the eldest and the only boy. The girl, as already mentioned, is the last of 7 children.

What may be noteworthy, is that, in spite of the still marked prevalence of infectious diseases in India, two of these children have already survived to adolescent age, though one knows that, in general, the life-span of mongoloids is not long. Even if they survive to adult age, they may show signs of premature senescence already in their thirties or forties.

Except for some vitamins and roborants and sedatives and tranquilizers to calm excessive excitement and destructiveness, all we could do was to instruct the parents about the nature of the defect, as far as this is already known, and about the possibilities of utilizing to the best the meagre resources of their children, such as their affectionate nature, their inquisitiveness and the often present interest in music and rhythmical movement.

A second special form of oligophrenia, cretinism or hypothyroidism, as the latter name indicates, due to congenital lack of thyroid hormones, is only represented by one case in our material :

- (13) *Gudu*, elder of two sons of a Hindu mechanic, had shown extreme retardation and inertia ever since birth. At the age of 7, when we saw him, the typical signs of the endocrine dysbalance were not so prominent, as he had already been treated with thyroid extracts since the age of 2. For the last few months, however, on someone's ill-advised suggestion, the parents had left away the drug. They consulted us, because, during this time, whatever progress and improvement had been gained, had been gradually dwindling away. A photograph taken at the age of 2, showed the typical cretin face : wrinkled forehead, plump, protruding tongue, dull expression and ill-proportioned body with short limbs and paw-like hands. A photograph taken a few months after thyroid treatment had been started, illustrated an amazing normalisation of these features.

At the time when we examined the boy, a few months after interruption of the medication, we noted : dry skin, wrinkled forehead, thick tongue, convergent squint, flat bridge of nose, loose tonus and poor motor coordination of the limbs. The child was dull, slow, apathic and only at times, when anxious or annoyed, would utter some growling noise.

Already one month after we had re-instated suitable treatment with thyroid tablets, the child presented a remarkably changed aspect.

One other boy in our group of children is an example of a particular form of oligophrenia, which is supposed to be connected with a defective hormonal function of the pituitary gland, known by an accumulation of authors' names as "Lawrence-Moon-Bardet-Biedl's syndrome" or, with reference to the areas most affected : "optico-diencephalic syndrome". This severe anomaly, in its most typical form, is characterized by obesity, lack of development of the genitals, degeneration of the retina, which can gradually lead to blindness, oligophrenia and polydactylia, i.e. the presence of more than 5 fingers or toes on each hand or foot. This syndrome can occur in several children of the same family. A hereditary component seems to be involved, though some authors assume that, under unfavourable intra-uterine conditions, some mutation in the genes may occur during embryonal life. One will see that the case observed by us can be regarded as fairly typical :

- (14) *Subhash*, aged 7, was tall and well-built, but rather too fat for his age. He had a broad "full-moon" face. On close inspection, one noted that he had 6

fingers and toes on each hand and foot. The palate was high, the spine lacked the normal curves, i.e. the dorsal kyphosis and lumbar lordosis. The genitals were poorly developed; the breasts, on the other hand, were excessively prominent. The skin of the back and the forearms was densely covered with hair. The child was mentally dull and used a badly articulated, agrammatical baby-language. The parents had noted signs of defective vision, particularly when the dusk set in (hemeralopia). They also mentioned the boy's excessive appetite, his fits of temper and destructiveness in play, his bedwetting and his generally retarded development. After a normal delivery, he was breastfed for one year, learned to stand only at the age of 3 and acquired his limited powers of speech very slowly. As to heredity, we know that the mother and one of her sisters both showed paranoid tendencies (ideas of suspicion and persecution). A paternal aunt of the mother was mentally ill. No cases of mental illness were known in the father's family. There was no blood-relationship between the parents. No chronic physical illnesses, such as syphilis or tuberculosis, had been signalled in either family.

A first child of this marriage was born in 1946. This boy had 6 fingers and toes. He died of pneumonia at the age of 6. After an abortion in the second month, a girl was born in 1948. She and her next younger sister, born 1950, were developing normally and showed no intellectual weakness. Our patient, born 1951, was followed by another abortion. A sister, born a few years later, again showed the same anomalies as the patient, in particular polydactylia. She died at the age of 1 of some fever. A last child, a boy born in 1957, presented no defects.

By the time Subhash was brought to us for consultation, treatment with pituitary and thyroid hormones had already been attempted in several series, according to the father, with temporary success. Apart from recommending continuation of this medication, which, however, due to import restrictions, was difficult to get, all we could do was to point out to the father some awkward inconsistencies in his attitude, which wavered between bribing the child with false promises and threats of rejection and often provoked helpless weeping in the poor boy. The mother's almost psychotic alternation between affectionate clinging and utter carelessness was beyond our reach.

If one goes through recent literature on oligophrenia, one finds an increasing interest in biochemical investigation of body-fluids and various stages of metabolism. These studies have already led to distinction of a few fairly well defined types of mental deficiency, which are characterized by certain faulty stages in metabolism, due to lack of enzymes and inability to utilize or transform certain amino-acids. Continued research in this direction promises not only further knowledge about the physical correlates of the mental defect, but possibly also methods of treatment.

Interesting and hopeful as one may find such discoveries, one may not be quite able to share the enthusiastic certainty of some authors and their followers that

thereby the riddle of oligophrenia is solved and its cause proved. This question of the absolute and exclusive validity of any results which the so-called "basic sciences" contribute towards a deeper insight into the mysteries of human life, is nowadays a fundamental one. Not only various schools of experimental research and theoretical thought, but also modern trends in psychiatric practice seem to base themselves on the purely materialistic assumption that mental phenomena are "caused" by measurable and predictable chemical or electrophysical processes in the body substance. One would, however, probably remain considerably closer to the finest Indian tradition of philosophical wisdom, if, quite on the contrary, one doubted that so fundamental a deviation in human existence, as e.g. idiocy, could merely be the result of some alterations in the arrangement of certain molecules or chains of molecules. Would it not betray more humility and respect before the mysteries of life and perhaps also come nearer to the truth, to assume that such biochemical phenomena may merely provide the conditions, or in other words the material channels, for the manifestation or actualisation of forces that lie far beyond the reach of microscopic lenses and refined chemical analysis ?

The biochemist might triumphantly argue that a certain child cannot produce normal brain activity *because* a ferment-system is blocked or the ability to utilize an important amino-acid is lacking. Though we cannot accept a statement of this kind as the ultimate truth, it may, however, open a way towards a deeper understanding. The biochemist's statement means that a mentally deficient child cannot transform the material offered to him in the form of food, possibly already through the maternal blood during pregnancy, into his own human substance and energy. Corresponding to this physical phenomenon, we find, in the mental sphere, an inability to assimilate, to form readily available associations and mental representations with that which is encountered in the outward world. The two defects are no doubt in some way correlated.

What, however, if both these outward phenomena pointed to the same central problem : an inability to receive the outward world into one's own innermost self, a persistence of a less developed type of consciousness which, as for instance the existence of a stone or other inanimate object, is hardly "self-luminous", but depends on being illuminated, on being given a place, by a being with a more penetrating light of conscious existence ? If, furthermore, we see that human existence can occasionally remain at a stage at which so many of its essential features seem to be lacking, one may be tempted to ask, what the meaning of these crippled or immature existences may be. We cannot answer this question, but only offer a few thoughts that might stimulate further reflection.

Are such poor creatures perhaps the shadow, against which we realize our own power of light ? Or a special challenge to our human task of taking care, even if no satisfaction of parental pride, no appreciation for hard effort and no paying back by filial piety and support can be expected as a reward ? Perhaps a reminder that we, the "normal ones", also depend on a greater light for the true illumination of our being, a light against which all our learning and wisdom may be as much a cloud of unknowing

as to us the ignorance of the idiot? Or should these unfortunate creatures, who seem to be deprived of all ability to develop an inner world, serve as a warning to all the many who, though they have this ability, persist in disregarding and neglecting it, continuing all their lives to build up their fool's paradise with the pleasures, commodities and opportunities of this external world instead of realizing the kingdom within? Or should one take recourse to the explanation provided by the Indian theory of rebirth?

Reflections of this kind may not only be necessary to prepare oneself for discussions with parents who are seeking a deeper understanding for their children's handicaps, but should help to form a true base and motivation for any medical, educational or social service to the mentally deficient.

(c) *Combinations with other psychiatric disorders.*

One may remember that, in chapter 4 of the general part, the problem of classifying combinations of two or more psychiatric affections was discussed and that we proposed to follow, as far as easily practicable, the principle of regarding the earlier and more constitutional illness as basic and primary. The group of oligophrenias therefore, for most statistical purposes, includes a whole number of cases in which the basic mental defect was complicated or overlaid by other organic affections or by functional superstructures. In Table 2 we are presenting the grouping of these combinations.

TABLE 2.

Combination of oligophrenia with other psychiatric disorders.

	Moron		Imbecile		Idiot		Total		
	M.	F.	M.	F.	M.	F.	M.	F.	T.
Total cases in group	15	2	23	9	11*	5	49*	16	65*
Total cases with combinations	15	1	13	3	2	2	30	6	36
	94.1%		50.0%		25.0%		55.4%		
With postenceph. state	2	..	2	..	..	..	4	..	4 (2)†
With epilepsy	2	..	5	1	2	2	9	3	12 (2)
With neurosis	12	1	4	2	..	..	16	3	19 (4)
With infantilism	2	..	..	..	..	..	2	..	2
With infantile psychosis	..	..	1	..	..	..	1	..	1
Withadolesc. psychosis	..	..	1	1	..	..	1	1	2

* These figures include the one Anglo-Indian boy.

† The figures in brackets indicate those cases in which the basic disorder was combined with two other psychiatric affections, e.g. postencephalitic state and neurosis or epilepsy with functional complication. The figures for the individual combinations therefore do not add up to the totals given in the first column.

One will note that, in 4 cases, the combination was a double one, in 2 with post-encephalitic state plus neurotic superstructure and in 2 with symptomatic epilepsy and functional complications.

As we have already pointed out, a functional addition which can be clearly distinguished from the basic defect, cannot be expected in the most severe forms of oligophrenia, as the formation of neurotic symptoms presupposes not only a certain sensitivity that allows the child to be impressed by unfavourable environmental conditions, but also a certain differentiation of emotions and variability of behaviour which could lend outward expression to inward tension or distortion. Both these fine distinctions seem to be lacking in idiots and in many imbeciles.

Amongst the morons, as mentioned earlier, there is only one case left which was without any recognizable combination or addition. The proportion of cases which presented complications, from 94.1 per cent in this group, decreases considerably to 50 per cent amongst the imbeciles and dwindles further, when we come to the cases of idiocy, of which only 25 per cent were combined, all with epilepsy.

A few examples will demonstrate best, what kind of cases we have placed into these combined groups :

First a case in which we had reason to suppose that a mental weakness existing since birth had been complicated by a later febrile illness with encephalitic symptoms :

- (15) *Zamir*, a Muslim boy aged 11, was the second of 4 children of a clerk. His elder sister, aged 16, suffered from epilepsy. The 2 younger siblings were normal. The mother seemed to be mentally rather limited. As the boy himself, she was squint-eyed.

Zamir had been mentally dull since earliest infancy. He learned to walk at 2, and started talking at 3. At about that age, he had an attack of high fever, during which he was delirious. At the age of 6-7, he suffered from small-pox. After the febrile illness at the age of 3, the parents noted increased mental dullness and restlessness, and retarded physical development. Attempts at teaching the boy remained fruitless. At the age of 11, when we saw him, he lacked understanding and discrimination even for simple everyday situations. At times he went into fits of anger.

On physical examination, we found a bulky head, strabismus (squinting), asymmetry of innervation of the facial muscles, of tonus of the limbs and of some of the reflexes. Speech was indistinct. In dealing with toys, the boy showed a restless inquisitiveness.

The signs of organic brain-damage might of course have been present at birth. But, as pregnancy and delivery had been uncomplicated and as a definite deterioration in the child's state was noticed after the febrile illness, before which he had developed at least to the point of learning to talk, one is probably justified

in assuming a congenital mental deficiency of a milder degree complicated by a febrile illness of encephalitic type.

As the combinations with epilepsy are the only ones that occur amongst the idiots, a case of this group is to be taken as an example :

- (16) *Nirdosh*, a Hindu of scheduled caste, was the eldest surviving child and only son of a mill-worker. His only sister, 7 years younger, was normal. No cases of mental illness were known in the family.

The boy was born at term by uncomplicated delivery. He was breastfed for 4 years. When he was a few months old, the parents noted that he showed little signs of activity and interest in his surroundings. He learned to walk at 2 and to talk at 5. When he was one year old, he started having epileptic fits. Recently at the age of 8-9, these fits had increased in frequency and duration, at times lasting for several hours.

On examination, we noted a big head, rather flat in the occipital region, where a scar with uneven bone edges could be palpated. Some of the responses to reflex stimulation were abnormal, particularly on the left. The left leg was less developed and came down more heavily in walking than the right. The left hand at times performed athetoid (unsteady) movements. The child was restless, fidgety and could not engage in any constructive activity with bricks or other toys.

According to the parents, he had not learned to attend to his own needs and was quite uninhibited and indiscriminate in his eating. At times he went into violent fits of anger.

Though, at the time when we examined the boy, one could not distinguish, whether the mental defect was basic or only due to epileptic deterioration, the history given by the parents : lack of activity and interest already before the first convulsions set in, makes it likely that oligophrenia and epilepsy were both the consequences of the same brain-damage, which, however, may have been accentuated in later years by typhoid at the age of 6 and the head-injury of which we noted the scar.

Some of the cases in which the basic mental defect, usually of mildest nature, is overlaid by neurotic symptoms, will have to serve later as illustrations for harmful parental attitudes. The following history, however, may stand as an example in this present context :

- (17) *Subodh* was referred to us by the District Psychologist, whom the parents, on a visit from a city outside U.P., had consulted first. The 12 year old Brahmin boy looked dull and depressed. He seemed to have difficulty in grasping any question and often would answer in a vague manner or obviously just confabulate something. He could only count to 25, and refused to cooperate in any test

going beyond this. Physically, we noted irregular teeth, the upper row protruding, and brisk, but symmetrical reflexes.

His parents complained about his mental retardation, his lack of memory and of interest in learning. Two older brothers and one elder sister were successfully engaged in higher studies, and everyone seemed to expect that this youngest son should follow their example. Though Subodh had developed very slowly, learning to sit only at 2, to stand at 5 and to talk after 5, he already was sent to an English convent-school at the age of 7. After 2 years, the school refused him, as it was quite obvious that he could not learn or, as the parents chose to express it, "did not want to learn". The ambitious father used to beat him and to close him into a dark room, hoping to cure the child from this "unwillingness" to come up to his expectations. The mother was more kind-hearted and understanding, but could not stand up against the father's harsh and overdemanding attitude.

It is possible that any congenital mental weakness may have been exacerbated by a prolonged state of illness after small-pox vaccination at the age of 10 months and, at the age of 10, by a fall from a cycle, after which he remained unconscious for 2 hours. Whatever causes the mental dullness, which was noted since infancy, may have been due to, its effects had certainly been increased by neurotisation in the form of anxiety, discouragement, depression and lack of self-confidence, provoked by the exaggerated ambitions of the father.

This boy might probably have developed quite harmoniously to a modest degree of common-sense knowledge and some useful activity, if he had had the chance of growing up in a less demanding environment. Being faced with learning English at a time, he had hardly acquired any command over the familiar Hindi, must have been particularly frustrating and disorienting for the mentally limited boy.

An example of what we considered as a double combination of congenital mental defect with later encephalitis and neurotic superstructure, will at the same time demonstrate the consequences of a form of parental rejection :

- (18) *Ramchandra*, aged 12½, was of South Indian origin. The family, however, had lived in the North since long before his birth as the youngest of 4 children. Again, all 3 elder siblings were engaged in higher studies.

As the mother had suffered from some "heart trouble" after an abortion, she very much resented a further pregnancy, when this last child was to be born. She did not feel well while bearing the child, and we have reason to suspect that she may have attempted abortion. The boy was born long after term and developed slowly. The mother's description rendered it probable that he was mentally deficient right from the start. We can, however, not quite exclude that any

dullness noted may have been due to the parents' neglect of this quite definitely unwanted child, and that any organic element may only have been added, when, at the age of 2, the boy had an acute illness with vomiting, convulsive fits, unconsciousness, and further convulsions in fever one year later, when ill with chicken-pox.

In school, he attended first class for several years without profit. Even with tutors, he would not learn anything beyond just spelling out a few words. The parents reported that, outside home, the boy could behave much more reasonably than within the family.

When we examined him, we actually found that, in the presence of his strict and irritable father, his performance seemed to be reduced by anxious stupor and a certain element of spite, while, when seen alone, he was freer and more constructive in his performance. He produced drawings which technically resembled those of a child aged 4-5, but which did not lack a certain humorous animation. In any test situation, he would either try to cling rigidly to some model, if this was possible, or then he would persevere in a once gained achievement of his own. He was able to name objects and understand the meaning of pictures and even to read a few words.

Again, this boy, though probably burdened with a double handicap of mild congenital mental deficiency and later organic complication, of which we noted the residues in the form of pathological neurological signs, might have developed far better, if he had not been exposed to the parents' negative attitudes. Both parents on one hand quite openly cursed him and expressed their wish that he should never have been born, but, on the other hand, also showed some kind of triumphant satisfaction about the boy's clinging to them, probably out of sheer necessity, as he had no one else to depend on ! They were full of complaints about his dullness, his lack of concentration, his fits of anger and quarreling, his habit of collecting useless rubbish and his getting into all sorts of mischief. Though the boy could certainly have been helped to some extent, not only by direct contact with the psychotherapist, but also by parent-guidance, the parents showed no interest beyond the initial stage of consultation.

The two cases in which we assumed a combination with general infantilism and the one in which an autistic development seemed to be superimposed on mental deficiency, will be mentioned with greater profit in connection with the corresponding groups. We are aware that our classification of these 3 cases is somewhat doubtful. It expresses perhaps less our conviction that the two disorders in question were actually associated, than rather a differential-diagnostic hesitation about labelling them neatly as the one or the other only. One finds, in fact, in recent literature, more and more doubts, whether some of what has up to now been regarded as congenital mental deficiency, may not much rather be due to an early emotional distortion than to a primary lack of intellectual potential.

The situation is much clearer with regard to the two cases of mental defectives who developed psychotic symptoms in adolescence. Even in these, however, one might prefer to regard the psychotic manifestations rather as a "puberty-crisis" or a "dysphoric state", as oligophrenics often manifest it, and not as a regular schizophrenic process superimposed on the mental deficiency. Again, a presentation of these 2 cases, one boy and one girl, will find a more suitable place, when we come to the group of psychotic adolescents.

(d) *Characteristic features in our Material.*

While under the last 3 headings we have dealt with more theoretical questions of classification, differential diagnosis and origin of oligophrenia, we now come to the particular features which characterize our small group of Indian children belonging to this category. In presenting them, we shall proceed in the same order followed in the general part and in the synoptic tables (Tables XVIII and XVIIIa).

(1) *Distribution according to sex.*—The synoptic tables show that, with the exception of the group of infantile psychosis and the minute group of organic cases, the sex ratio for oligophrenics with 3 boys against 1 girl, is the one which is most heavily weighed down on the male side. This proportion is even more accentuated in the group of oligophrenics amongst our adult patients, where it amounts to 3.5 men to one woman !

Studies of heredity in the West have shown that certain forms of mental deficiency seem to be handed down more frequently to boys than to girls, even if the mother is the carrier of the responsible genes. This might explain a greater frequency of male patients amongst the hereditary forms. Furthermore, some authors maintain that, in intrauterine and early postnatal life too, a boy's organism is more delicate than a girl's.

As we have shown earlier, it would however hardly do to attribute the sex ratio in our material only to intrinsic factors of this kind. Particularly if we consider that in the group of morons, where consultation perhaps depends most of all on parental ambitions and educational aspirations, the ratio of boys to girls is even 7.5 : 1 (See Table IV), while for imbeciles it is 2.5 : 1 and for idiots 2 : 1. One can hardly escape the conclusion that social and cultural factors are more responsible for these figures than biological ones.

Girls, for whom, until quite recently, the possibility of getting a higher education was much less important than for a boy, are presumably not only less likely to be brought for consultation for minor grades of mental deficiency, but also run less risk of being driven into neurotic defences by overdemanding parents. The most decisive criterium for getting them examined and treated is possibly, as we have already pointed out, the parents' wish to get them married. If this is correct, we shall find this tendency reflected in the age-pyramid, to be studied next.

(2) *Distribution according to age.*—The age pyramids for the individual groups have already been given in Graph-I b. For oligophrenia, the graph shows a more

uniform distribution over all ages amongst the boys, while, apart from a maximum at the age of 7-8, presumably school-entry age, we find most of the girls concentrated in the highest age group of 11-16, i.e. at the approach of adolescence and marriageable age. The implications of this pattern of distribution have already been discussed earlier.

In the table which gives the age distribution for the 3 grades of mental deficiency (Table 3), we find that the only children who were brought at an age below 6, one girl and 7 boys, belong to the group of imbeciles. The defect of a moron is often only discovered at a time when he has to face wider sectors of society and systematic learning in school, and we need therefore not wonder, that the lowest age at which any moron was brought, is 8-9 years. As most of these children with mild defects were furthermore only seen by us after some functional disorder had superimposed itself

TABLE 3.

Distribution of oligophrenics according to age.

	Moron		Imbecile		Idiot		Total		
	M.	F.	M.	F.	M.	F.	M.	F.	T.
Total cases in each group	15	2	23	9	10	5	48	16	64
1-2 years old	..	..	..	1	..	..	..	1	1
2-3 years old	..	..	..	..	..	..	..	..	..
3-4 years old	..	..	1	..	..	..	1	..	..
4-5 years old	..	..	5	..	..	..	5	..	5
5-6 years old	..	..	1	..	..	..	1	..	1
6-7 years old	..	..	1	..	..	..	1	..	1
7-8 years old	..	..	1	2	4	2	5	4	9
8-9 years old	2	1	..	..	..	..	2	1	3
9-10 years old	1	..	1	..	2	..	4	..	4
10-11 years old	1	..	4	..	..	1	5	1	6
11-12 years old	2	..	2	1	..	..	4	1	5
12-13 years old	5	1	2	2	..	..	7	3	10
13-14 years old	1	..	..	1	..	..	1	1	2
14-15 years old	2	..	4	1	1	1	7	2	9
15-16 years old	1	..	1	1	3	1	5	2	7

on the basic trouble, we also have to allow for a time-lag between the onset of the harmful parental influences and the manifestations of a distortion provoked by them. Where the group of idiots is concerned, it is more surprising that no children younger than 7 years were brought, as severe defects can usually already be discovered in early infancy. Probably even parents of idiotic children still may entertain hopes of improvement up to school age or at least tolerate the child as long as intellectual performance is not a necessary requirement for his social status outside the family.

(3) *Reasons for Consultation.*—According to Table IV, as one would expect, the intellectual defect was the universally formulated reason for consultation. Behaviour problems, however, were indicated in almost 80 per cent of the children. These may partly have been due to the basic defect ; some of them certainly were the signs of superimposed functional distortion. 35·9 per cent of the children had convulsive fits at one time or the other. One will see that only 10 of these 23 cases were counted as “combinations” with epilepsy. Where the fits had only occurred sporadically in early infancy or occasionally during febrile illness, we did not label them as a permanent complication or combination.

One will see that the list of main symptoms also contains a column for delinquent features and that 5 oligophrenic children figure in it. As the problem of juvenile delinquency deserves special attention, and as a separate study on this subject has already been completed from this same material, we propose to add a special chapter on it later. [Hoch (18)].

The “motor handicaps” mentioned, were due to brain-damage, which at the same time formed the basic condition for the mental defect.

(4) *Local origin.*—Table III shows that slightly more than half of all oligophrenic children were living in Lucknow itself. A little more than one third were brought from towns in U.P., and less than 5 per cent from villages in U.P. Together with the cases brought from villages outside U.P., we get a percentage of 7·8 per cent children from rural surroundings. We have already repeatedly ventured the explanation that this small figure in no way reflects any distribution of true incidence of oligophrenia, but only such factors as greater tolerance for mental defects in largely illiterate surroundings, lack of information about modern medical possibilities and difficulties in reaching such services, even where they exist. Considering all these factors, one may even wonder, that any children at all were brought from villages.

If we examine the 5 cases more closely, we actually see that some of the families do not represent the typical village population, but would rather have to be called people “stationed” in villages, as *e.g.* a tahsildar, a businessman and an engineer.

(19) *Parshottam.*—The one boy who can probably be said to be of true village origin, was the only surviving one of 17 children of a poor carpenter. Though both parents were themselves mentally dull, they apparently spared no trouble

to find some help for this severely handicapped, imbecile, dysplastic and brain-damaged child, who was their last hope.

Any planning of educational services for mentally deficient children will have to take account of the fact that there seems to be a demand for special school not only in the biggest cities, but also in smaller towns. As long as a child is well cared for in his own family, there is no reason why he should be taken away from home to a far-away residential institution. Educational facilities in the form of day-school, will therefore have to be organized and distributed in such manner that they can serve the children of many different areas even outside the big cities.

In the general chapter on local origin, we had mentioned the problem of migration and refugees. The 3 cases of Pakistan refugees from the group of oligophrenics have been shortly summed up there, and one of them (9), has also been presented as an example of mongoloid idiocy.

The one Anglo-Indian boy (6), representing the "foreign" element in this group has also already found mention as an example of particularly obvious hereditary influences.

(5) *Community and Caste* (Graphs II and III).—The distribution of the oligophrenic children according to community, presents no extraordinary deviation from the average for all children, nor from the total for all our patients including the adults.

With regard to Hindu caste, one may be somewhat surprised by the predominance of Brahmins. This probably does not reflect any particular frequency of incidence in this caste, but, as the similarly high figure in the postencephalitic group, perhaps rather higher educational standards, against which even slight intellectual weakness will be noted and create concern. We see in fact (Table 4) that almost

TABLE 4.

Distribution of Hindu castes amongst the grades of mental deficiency.

	Moron		Imbecile		Idiot		Total		
	M.	F.	M.	F.	M.	F.	M.	F.	T.
Total cases in groups	15	2	23	9	10	5	48	16	64
Total of Hindu children	13	1	16	7	8	5	37	13	50
Brahmin	7	1	4	1	1	1	12	3	15
Kshatriya	1	..	5	2	2	1	8	3	11
Kaisth	1	..	..	2	1	1	2	3	5
Baniya	2	..	4	2	2	2	8	4	12
Shudra	..	..	2	..	1	..	3	..	3
Caste ?	2	..	1	..	1	..	4	..	4

50 per cent of the children with the mildest degree of mental deficiency (moron), are Brahmins, while in this group we find no Shudra. In the groups of imbecility and idiocy, on the other hand, where the 3 Shudra children are placed, the proportion of Brahmins falls down to 15.6 per cent for imbeciles and 13.3 per cent for idiots.

As most of the children from the moron group have been brought, not so much for the basic defect, but for some complication, one might also suppose that their having to grow up in surroundings with high cultural demands, as *e.g.* in a Brahmin family, may place excessive strain on them, which can result in a functional distortion. We find, in fact, that 75 per cent of the Brahmin children classified as morons presented neurotic features.

(6) *Occupation of Father or Guardian (Graph IV).*—The predominance of children from business and service families probably reflects the proportion of these two sectors in the town population from which the children mainly come. The small share of landowners and farmers has already been commented on repeatedly. One example of a child from the craft- and labour-class has been given above (19), to illustrate village-origin. Just as for the distribution of scheduled castes, we also see that children from the still largely illiterate class of labourers and small crafts are only to be found amongst the imbeciles and idiots, but not amongst the morons. This same distribution is also to be found in the oligophrenic group amongst our adult patients. The only few Shudras and the one patient from a family of craftsmen were all amongst the imbeciles and idiots. This certainly confirms our impression that milder intellectual deficiencies are only thrown into the foreground in surroundings, where great value is placed on literacy and higher education, whereas the gross defects will also constitute a problem in less educated families. This, however, means, that with an increase in literacy, more cases of mental deficiency will draw the attention of their parents, teachers etc., who, in their turn, may raise demands for educational facilities.

(7) *Joint Family (Graph V).*—In the general part, we pointed out that our figures for the number of children from joint families in the congenital-organic groups are not reliable. The small percentage of only 4.4 per cent for the "pure" oligophrenic cases, (one imbecile, one idiot), may be due to lack of information rather than to actual differences in incidence. Still, one cannot quite exclude that within the joint family the question of a child's future "economic usefulness" may not be as important as in an individual family and that, therefore, mentally deficient children may find better tolerance and shelter.

Amongst the combinations with functional disorders, we find a higher rate of 15.8 per cent children from joint families. This figure again might be due to more accurate information about these children, for whom environmental and emotional factors seemed more important and were therefore better investigated than the purely congenital cases. It may, however, have its significance in view of the high rate of joint families in the neurotic group and that of the functional combinations in the postencephalitic group.

(8) *Lack of Parents*.—(Table VI) Of 4 children who had lost one or both parents, 3 presented functional superstructures :

- (20) *Vijya*, the one imbecile girl who, at the age of 12, showed no significant emotional distortion, though she had lost her mother at the age of 3, grew up in a big joint family under the care of an accepting stepmother and a concerned father.
- (21) *Ram Krishan's* childishness, excessive anxiety and fits of temper, which accentuated a slight congenital mental deficiency may have been less a direct consequence of his having lost his father at the age of 7 than much rather due to his widowed mother's possessive clinging to this youngest child, who alone had remained within the reach of her devoted affection, after the 7 older children had grown up and, some of them, left home.

At 14, the boy could certainly have performed at least some simple work in the house or the family-shop, if it had only been a matter of his actual intellectual abilities. On observing him, however, one got the impression that, to save himself from effort and responsibility, he made himself appear more stupid than he actually was. A father's good example and discipline might have saved this boy from becoming the pampered pet of a clinging mother.

- (22) *Asha*.—Deprivation from motherly care through separation of the parents and, already before that, though the mother's irresponsible behaviour, seems to have been an important factor in hampering *Asha's* development. When the girl, only daughter of a Sikh landowner, was aged 6, her father decided to give his loose-charactered wife, by an act of separation, the freedom from restraint and responsibility which she had already claimed for herself ever since this only child had been born.

After a forceps delivery, *Asha* was weak and developed slowly. Her mother neglected her, as she was more interested in roaming about with men. After the parents separated, *Asha*, who remained under custody of her father, was sent to a boarding-school. She could not learn much and was reported to disturb by her mischievous behaviour.

When we first saw the girl at the age of $12\frac{1}{2}$, she looked dull and lost and showed a marked lack of inhibition and discrimination. Unfortunately, the father, who only seems to have cared for the girl in rare fits and starts, gave us no opportunity to investigate the situation thoroughly. We got the impression that the girl was a moron ; but one cannot exclude that the deficient mental development itself, and not only the emotional superstructure, may already have been a result of early maternal neglect.

Two years later, then aged $14\frac{1}{2}$, the girl, about whom we had heard nothing in the meantime, was again brought for just one hurried visit, this time in a

state of great anxiety and confusion. What we could find out during that one consultation from herself and her father, rendered it very probable that, in her lack of discrimination and of firmness of character, she had followed the example of her mother. She seemed to have got into bad company and there were signs of an early pregnancy.

Illegitimate motherhood in slightly mentally deficient young girls is a risk which, in the West, poses quite a few problems to gynecologists, psychiatrists and social workers. Their lack of knowledge about the facts of life, their inability to grasp the full significance of a situation, their deficient control over their instincts and emotions and the often present suggestibility, expose them in quite particular measure to being made use of by irresponsible men or possibly by equally mentally deficient "friends". One will, in this connection, also remember the Anglo-Indian boy (case 6), whose parents, two mentally deficient siblings committed incest.

Up to now, except perhaps for incestuous relationships within the family, Indian girls, even when lacking discrimination and control, were protected from happenings of this kind. The freer relationships between young people and the emancipation of girls in general, which are more and more replacing the strict old tradition of "purdah", may give rise to increased risks of illegitimate pregnancy even in girls who are better protected than the motherless Asha in our example.

(9) *Heredity*.—(Table VII) Table VII classed oligophrenia as one of the groups with the highest incidence of psychiatric disorders amongst family members, second only to the two psychotic groups. Of the 51.5 per cent of cases in which any heredity had been signalled, only 17.2 per cent, i.e. about one third, had relatives who also were mentally deficient. The next lower rate for any single disease is that for syphilis, which was present in 15.6 per cent of the families, while epilepsy was mentioned in 10.9 per cent. The proportion of congenital-organic disorders in the families to conditions of functional type is 1 : 0.6, i.e. showing a distinct predominance of the former.

Table 5 gives the detailed distribution for the 3 grades of mental deficiency.

According to textbook theories, which maintain that the hereditary forms of oligophrenia are the milder ones, one should expect a higher rate of specific heredity in the moron group and perhaps amongst the imbeciles. In our 3 groups, we find the rate for heredity highest, generally for all psychiatric disorders and specifically for oligophrenia alone, in the group of imbeciles. For idiots, as expected, both figures are lowest. The relatively low rates for the moron group may possibly be explained, if one reflects that, in a family where oligophrenia is hereditary, the relatives are less likely to experience a child's defect as pathological. We are therefore more likely to see the non-hereditary forms, i.e. the children from families with average or above average intelligence.

It may be of interest to compare these figures with those we have calculated for the oligophrenic group amongst our adult patients. There, the figures for general

TABLE 5.

Heredity according to Grades of Mental Deficiency.

	Moron		Imbecile		Idiot		Total		
	M.	F.	M.	F.	M.	F.	M.	F.	T.
Total cases in groups :	15	2	23	9	10	5	48	16	64
Total cases for which heredity known :	47.1% 6	2	62.5% 15	5	33.3% 3	2	24	9	51.5% 33
Oligophrenia	2 11.8%	..	5 25.0%	3	1 6.6%	..	8	3	11 17.2%
Epilepsy	1	—	4	1	—	1	5	2	7 10.9%
Syphilis	1	..	6	1	1	1	8	2	10 15.6%
Other organic disease	..	..	1	..	2	..	3	..	..
Neurosis & Psychosomat.	2	1	3	..	1	—	6	1	7
Psychosis	3	..	1	..	1	..	5	..	5
Strange character	1	1	3	1	1	..	5	2	7

heredity are : 60 per cent for moron, 76.9 per cent for imbecile and 100 per cent for idiots ; the specific figures for oligophrenia amongst relatives are : 13.3 per cent for moron, 28.5 per cent for imbeciles and again 100 per cent for idiots. We must, however, remark that the group of idiots who were brought at an adult age only counts 3 patients. It is of course quite possible that the oligophrenic relatives may have been siblings who were exposed to a same intrauterine or postnatal damage as the patients themselves. One will note that the specific figures for the groups of morons and imbeciles come remarkably close to those we have calculated for the children. The higher general rates may be due to the fact that, for adults, the sibling row is more likely to be complete than for children, so that siblings or cousins may be included, which for children cannot enter into the count yet.

Syphilis figures in 15.6 per cent of the families of oligophrenic children, whereas in the adult group the corresponding figure is 9.4 per cent.

If, amongst the adults, the number of families in which one or more siblings died in infancy, with 62.5 per cent, is considerably higher than the 39.1 per cent calculated for the oligophrenic children, this may possibly also be partly due to the fact that the sibling-row for many of the children was not complete yet : but it may also reflect the general reduction in infant mortality during the span of one generation.

If parental heredity, or perhaps expressing it more cautiously, the incidence of psychiatric disorders in the parents alone, is considered, oligophrenia does not take so prominent a place with 37.5 per cent, but still remains first amongst all congenital-organic groups. The main single disease signalled is syphilis. Second in place come neurotic disorders, particularly amongst the mothers. Oligophrenia was present in one father and 3 mothers. In one case (19) both parents were mentally limited. The rate for "specific" parental heredity is therefore only 4.7 per cent. We have, however, already pointed out that parents who themselves are mentally deficient, are not very likely to bring their children for consultation, except in such extreme cases as the one described (19), who was the only surviving offspring of 17 children of a mentally dull couple. This case, incidentally, illustrates very instructively what we have said earlier about the possibility of correlation between psychiatric heredity and high sibling mortality : The boy had definite signs, not only of congenital malformations (Spina bifida occulta, kryptorchism, possibly a congenital heart vitium), but also of rickets and corneal opacity, probably due to small-pox, i.e. residues that might point to some postnatal neglect or at least to the poor village people's helplessness and ignorance in taking care of a child, in addition to the inferior genetic material they had transmitted to him and presumably also to the numerous deceased siblings.

An interesting field for studies on parental heredity in the biological sense and as a "pseudoheredity" through the colouring of the emotional atmosphere was given in some of our groups, when either 2 or more children of the same family or one of the parents and a child were brought for consultation. Of the first possibility, we have already given an example in the family of Shankar (4), in which parents and all siblings seemed to be affected by syphilis.

A case in which we had occasion to examine and treat a boy and his mother is the following :

- (23) *Hasan's* mother had been treated at our Center successfully for a state of nervous exhaustion, characterized by anxiety attacks and some paranoid suspicions. Having gained confidence, the family later also brought the 10 year old son, who had been retarded in his mental development since earliest infancy.

Born with the umbilical cord twisted round his neck, the child seems to have shown some signs of asphyxia during the first few days. His digestion remained delicate all through infancy, and at times he had urinary trouble. A brother, 3 years older, was intelligent, but also rather sensitive and anxious. He was living with his grandfather, away from the family. So, though Hasan at times had to stand comparison with him, rivalry was not as acute as it might have been, if the two brothers had constantly been seen beside each other. At the time we got to know the boy, however, his twin sisters, aged 6, had begun to catch up with his poor attainments in school, and he had to bear a lot of teasing from them.

On examination, we found signs of brain-damage in the delicate boy. His ability to perform in school or in any test situation seemed to be just as much

hampered by his anxiety and fear of failure as by the original mental weakness. Though both parents were accepting, the mother's repeated phases of anxiety and confusion must have had their effect on the sensitive child. Furthermore,—an example for the influence other family members can exert, even if the parents show normal concern !—he was subjected to his younger sisters' teasing and to the tactless remarks of a maternal aunt living in the same house, who favoured the elder brother.

In this case, though the brain defect itself was more likely to be of intrauterine origin, the accompanying sensitivity and tendency to neurotic reactions, may have been inherited. The paternal grandfather and the maternal grandmother both had had phases of mental illness. The parents were distant cousins. The mother's sister impressed us as highly neurotic, and the father's elder brother, at the same time the husband of this maternal aunt, consulted us later for some signs of anxiety neurosis.

(10) *Number of Siblings and Special Position in Sibling Row.*—While the last column, for heredity, was heavily marked in the synoptic table, the data for number of siblings and special positions amongst them do not indicate any extraordinary situation in the group of oligophrenics.

The possible significance of the relatively large families in this group in frustrating demographic planning, has already been discussed. The most numerous family, in which 16 out of 17 children had died, has already been presented in 2 connections (Parshottam, 19). It is largely due to this one family in particular that the rate for siblings who have died, with 21·8 per cent, comes second only to the epileptic group, in other words that only 4 out of every 5 children in these families survive.

As to special position, the excess of actuals beyond the maximum possible figure (Table XI) for the oligophrenic group as a whole is almost negligible with 5·8 per cent. We have, however, already drawn attention to the fact that, for the cases combined with functional disorders, this rate rises to no less than 18·3 per cent. From this difference, which we also find in the other congenital-organic groups, we drew the conclusion that oligophrenic children have less chances of developing harmoniously, according to their capacities, if they become the center of attention and possibly of parental ambitions in a unique position in the family. The attentive reader may already have noted proof for this in some of the examples we have given of children in such positions. As the excess rate is particularly high, about 50 per cent beyond expectation, for eldest born and eldest surviving children, we shall give another example of this situation as the eldest, which will at the same time illustrate the disastrous effects of parents' ill proportioned ambitions for a mentally limited child.

(24) *Anand*, aged 8, son of a high Government official, Brahmin, was brought by his father because of his mental dullness, his "senseless talk" and his quarrelsomeness. The child, quite well built for his age, was dressed like a little gentleman, and the sun-topi on his head gave him an air of great importance. We found

out that he was the eldest and the only boy amongst 4 children. After a normal delivery, he remained weak and sickly and developed slowly. He often had high fevers, suffered from pneumonia several times and of typhoid at the age of 5.

When he was aged 2, a younger sister was born, but died after 10 months. The mother then continued to breastfeed him again up to the age of $3\frac{1}{2}$ years. Since a very early age, he had to wear eye-glasses. He learned to walk at the age of $2\frac{1}{2}$ and only started talking at 5. Already one year later, he was given a tutor and at 7 sent to school.

On examination, we found a bulky head, very short-sighted, squinting eyes, a slight deformation of the spine (scoliosis), some reflexes suspect for organic damage to the central nervous system and a general clumsiness of movements.

Though articulation and intonation of his speech were still those of a small child, he tried to use "big words". In the few simple tests which we administered, he was obviously out to cover up his ignorance by excuses, confabulations and other tricks. He would for instance grandly announce that he was going to draw a tree. When he saw that his product could not possibly be called a tree, he suggested that it was really a camel, but that it had got drowned and that leaves had grown on it. He could not even name the colours properly and was incapable of counting up to 100, though he was in second class in school.

Though the father also admitted that the boy had hardly made any progress in school, he proudly told us that, due to his father's high position, and his own physical strength, Anand had been made monitor in his class. The father also reported equally proudly, how his little son had managed to pass his exam by letting his neighbour do his paper for him, while he sat doing nothing. This confirmed our observation of the boy's attempts at bluffing during the tests. Apparently he had a quite good reproductive memory, but no capacity for logical grasping and for assimilating anything that was taught. While the father thus was rather overambitious and boosting up the boy's unjustified pride and his tendency to gain recognition by crooked means, the mother impressed us as mentally dull. We further heard that two paternal cousins of the boy were mentally deficient and that one of his younger sisters also squinted and was mentally retarded.

We thus have an example of a family, in which there seems to be some specific heredity of oligophrenia and in which, all the same, at least one of the parents has undue ambitions for the child, who happens to be the eldest and the only son. In a more sheltered position, perhaps with one or two elder brothers, the father's high expectations might not have weighed so heavily on him, though then perhaps, as some of the children we have presented earlier, he might have suffered from eternal comparison with brighter siblings.

(11) *Age of the Mother at Birth of the Child* (Table XII).—The rate for “young” mothers, aged below 20 at birth of the child, with 21·4 per cent, comes second only to the group of epilepsy. According to the tables on local origin, caste and occupation of fathers, we have no reason to assume that this figure could be determined by a predominance of families from lower classes or rural areas, where early marriage and child-bearing is still more customary than in the educated population of towns. The fairly high proportion of eldest children might have something to do with it ; but it is equally high and even higher in some of the other groups, where young mothers are less frequent. We thus may have to assume, as Chandra & Prasad (12) have stated in their previously mentioned article that : “The age of the mother affects child’s health. Congenital deformities are more common in children born to mothers before the age of 19 years and after 40 years. Abortions, miscarriage and still-births are also more common in such mothers.” While the rate for sibling mortality and, as we shall see later, for congenital malformations and disturbed pregnancies and deliveries for the group of oligophrenia all seem to be in support of this statement, we find no corresponding excess of “old mothers” in this group, except for the small sub-group of mongoloid idiots, for whom the percentage, with one mother aged above 40, is 25 per cent.

It is, however, hardly correct to correlate these figures for the whole group, unless we know, whether such features as malformations, high sibling mortality, difficult deliveries, actually occurred in the families with young mothers. On examining these data in detail, we actually find a 100 per cent correlation between “young mothers” and congenital malformations in the children for all those in the purely congenital-organic group. In children in whom oligophrenia was combined with functional trouble, this correlation does not hold good. This might mean that, on one hand, very young mothers are actually more likely to give birth to dysplastic children, but, on the other hand, one might also have to consider that a young mother of a mentally deficient child, who need not necessarily be dysplastic, may have more difficulty in showing proper concern and acceptance than a more mature woman, and that therefore one might find children of such young mothers amongst those with neurotic distortions.

50 per cent of the children with young mothers are first-born, while a few more are the first surviving ones after one or more born at a still younger age of the mother have died. A significant correlation with difficult pregnancies or deliveries cannot be found in our material. Sibling mortality in the families with young mothers is hardly higher than for the total group of oligophrenia.

(12) *Complications of Pregnancy and Delivery* (Table XIII).—In this column of our synoptic tables (Table XVIII), we again find high figures amongst the oligophrenics, second only to the group of infantilism. In the chapter on “causes” we have already drawn attention to the importance of a disturbed intrauterine life and a complicated delivery in producing brain-damage that can form the base for mental deficiency. Illustrating examples have also been given there.

(13) *The period of breastfeeding* (Table XIV).—Breastfeeding beyond the second year was reported by 12·5 per cent of the mothers, *i.e.* a figure just corresponding to the general average for our whole material. Half of these cases, however, are to be found amongst the oligophrenic children with neurotic features, for which small group, therewith, the rate for prolonged breastfeeding amounts to 21·0 per cent, second in place only to the group of infantile psychosis.

One may ask, whether perhaps the retardation of development, the torpidity and natural dependence of a mentally deficient child facilitates in a particular measure a mother's wish to cling to her child by this physical bond. While a mother might have some compunction in tying to herself a child who shows a natural urge to explore the world, her devoting herself in this way to a handicapped child will not only save her from guilt-feelings, but give her a good chance of clothing this defence against her own anxiety into an appearance of particularly fine motherly feelings.

In some cases, lactation was continued, as we have seen it in case (24), after the next younger child had died.

Two examples, one from the "pure" group, the other one a combination with neurotic features, can perhaps show, what attitudes may be involved.

- (25) *Mohan* was the only surviving one of 3 children of a Hindu Baniya family. The eldest child, a girl, had died 10 days after birth. A boy, who was also mentally deficient, grew up to the age of 11, when he died of small-pox. In the mother's family, there was one case of mental deficiency. The father indicated that he had had syphilis, but only after the patient's birth. Mohan, the youngest was born without complications, after a normal pregnancy. He was noted to be dull and unresponsive right from birth. As no other children were born after him, the mother, aged 21 at his birth, continued to breastfeed him up to the age of 5.

We do not know, whether at that age she stopped breastfeeding because the child started to move about, first by crawling, about one year later by walking, or whether, on the contrary, the child at last was free to venture out into the world after having been released from this close bond with the mother. He only learned to speak at 8 and, when we saw him at 15, with the physical signs of puberty already developed, he still could not talk distinctly and only with a very limited vocabulary. He was unable to take care of any of his needs. Examination showed signs of organic brain-damage.

It is impossible to say in this case, in which the mental defect amounts to idiocy, whether the mother's clinging to this only surviving child was facilitated by the boy's dullness or whether, on the contrary, the excessive motherly care may have prevented him from developing more of possibly available abilities.

- (26) *Sarala*, aged 14, was the daughter of a U.P. farmer. Her mother suffered from epileptic fits. A first brother died at the age of one month. Our patient

was born next and, for 10 years, was the only surviving child. One brother 3 years younger than her, died when 2 weeks old, another one within the first year. Only the youngest, a brother aged 4, was also surviving. Sarala was breastfed up to the age of 3. When, however, the next-born baby died, the mother again gave the breast to Sarala up to the time when she reached the age of 6.

The girl was dull and lethargic since earliest infancy. She learned to walk at 3 and to talk at 2. She certainly was already noticeably retarded, when, at the age of 16 months, she started having epileptic fits. While, as long as Sarala remained the only surviving child, she was pampered by the anxiously clinging mother, she suddenly was deprived of all special attention and favour at the age of 10, when the youngest brother, apparently a healthy and normal child, survived. The consequences of the mother's irritable and rejecting attitude, which, after the initial excess of affection and concern, the girl must have felt all the more, seemed to have led to anxiety, excessive shyness and lack of confidence. The father had the impression that, since the child had lost her place to the younger brother, her intellectual performance had deteriorated and the frequency of the fits increased.

(14) *Toilet Training*.—Lack of control over excretory functions was a frequent feature in the oligophrenic children examined. It looked, as if often the parents had not realized that any attempts at "education" of a mentally limited child would necessarily have to start with a patient training to some order and regularity in everyday matters. In some cases, a child was given a tutor or even sent to school, before he or she had learned independent toilet habits. In two extreme cases, one a boy of 4½, the other one a girl of 7, the parents reported that the children played and smeared with their excrements and at times even tried to eat them.

(15) *Early Neglect*.—Into the group of oligophrenics, we have placed one case in which early parental neglect seems to have led even to severe physical consequences :

(27) *Victor* was the eldest surviving child of a Christian businessman in a U. P. city. There is some suspicion that the father may have suffered from syphilis, though he himself only mentioned having been treated for gonorrhoea. The mother had always had poor health.

Before the patient was born, 2 boys and 2 girls had already died in infancy, while 2 further pregnancies had ended in abortion and one in a still-birth. The next child born after Victor also died, while 2 brothers, 6 and 9 years younger, had survived and were developing normally.

At birth, the parents noted no deformity in the child's body. About a week later, the mother fell ill, apparently with a prolonged febrile disease that prevented her from attending to the child herself. She had to stop breastfeeding, and it seems that, from then onward, the boy only got a minimum of care. According

to the father, he was just left lying in his favourite position, with his head turned towards the wall, away from all human contact and hardly ever picked up even for feeding. At the age of 6 months, he had typhoid. Weakened by this illness, he only weighed 5 lbs at 8 months. The first teeth were noted only at the age of 2. At about the same time, the boy made some attempts at creeping. When he started sitting at 4, the parents began to note that his bones were deformed in various parts of the body. In addition, he was mentally dull and retarded, lacking understanding and judgment. When he grew older, they observed that the boy avoided members of the family, while he could be quite friendly and sociable with outsiders.

When Victor was brought to us at the age of 10, he was quite good-natured and affectionate, but could hardly speak a few words. His whole body was very severely deformed : a narrow, long head, shaped asymmetrically, almost like the outer shell of a monkey-nut ; the dorsal spine curved towards the right, so that the right shoulderblade was sticking out, while on the left the chest was bulging out in front, with the lowest ribs practically touching the hipbone. Arms and legs were spindly and weak, hands and feet cold and damp with perspiration.

On closer study of the ill-shaped body and after asking the boy to lie down in his usual sleeping posture, we realized that all these deformities must have taken their start when, with bones probably softened by insufficient nourishment, fresh air and sun (rickets ?), the child was left lying constantly in one position : on the right side of the chest, the left side of the face and the chest slightly turned upward, the left leg drawn up and both arms slightly raised above the head ; the very same position in which, after its effect had become so-to-speak frozen solid, the boy still felt most comfortable at the age of 10.

It is difficult, in this case, to estimate, how much of the physical deformity and the mental defect may possibly have been due to a syphilitic infection and how far they may have been the direct result of this extreme early neglect ; probably we have to assume a combination of both.

(16) *Parental Attitudes (Graph VII and VIIa).*—In the examples already quoted, reference has usually been made to parental attitude, and a whole variety of different possibilities has thus already been demonstrated. We shall, however, add a few case-histories as illustrations for the attitudes found most frequently in the pure group of oligophrenia and amongst the cases combined with functional disorders.

(28) *Arfa.*—As a good instance of well-directed parental concern and acceptance, we can take the youngest child in our group, a Muslim girl, who was already brought at the age of 18 months.

The big, asymmetrical head, the weakness and slackness of the whole body, and some uncoordinated movements of neck and limbs, made it appear most probable

that the child had already been brain-damaged at birth. No case of psychiatric illness was signalled in the family; but we know that the mother had some abdominal trouble during pregnancy. Up to the age of 6 months, *i.e.* as long as one does not expect much spontaneous activity from a child, the parents did not observe anything abnormal. Later, they realized that the child could not sit up, that all muscles were weak and that movements lacked coordination. An attack of diphtheria and a "heat-stroke" about a month before we examined the child, seemed to have caused a further setback in the already retarded development. Though the signs of physical handicap (Amyotonia congenita ?) and mental deficiency already plain at this early age gave very meagre hopes for any future improvement, the parents took the fate of this youngest of their 3 children with great courage and a true determination to take proper advice and to make the best of the girl's poor capacities.

While rejection, which figures predominantly in the graph for all oligophrenic cases, concerns almost exclusively children who developed functional complications, diverging parental attitudes were only registered in the pure cases. We had pointed out earlier that, when the parents' attitudes differed, it was always the father who showed more concern and acceptance. This is illustrated by the following case :

- (29) *Baleshwar* was the second of 3 sons of a Hindu Government officer. His two brothers, one 7 years older, one 6 years younger, were healthy. During the large gaps between the birth of these children, the mother had several abortions. Abortion also was imminent, when the mother was pregnant with our patient. The situation, however, was saved and the child later born on term and without complications. The boy was breastfed up to the age of 2, learned to sit at 1, to stand at 2 and to walk at 3 ; at 5, he started to pronounce a few words. At 10, he had not acquired independent toilet habits yet. At the age of 2, he had small-pox and, after this illness, up to the age of 7, he occasionally went all stiff or even had some convulsions. At that time, the boy was living in a village and, as the fits were supposed to be a sign of possession by evil spirits, his forehead was branded with heated ornaments.

When the mother, a nervous, irritable, uneducated woman, realized that the boy would never develop normally, she lost all interest in him and expressed her annoyance by frequent beatings. The boy, on the other hand, began to show fear of his mother. When the father, on his visits from the city, where he had to remain for his work, noted this state of things, he decided to take the child with him. At the time when he brought Baleshwar for consultation, he had already succeeded in training him for a few everyday performances and had even discovered his interest in music. He humbly took the necessity for special care and patience as a God-sent opportunity for practicing these virtues and went so far in his acceptance of the miserable looking little creature that, without any shame and embarrassment, he would take the child with him even on visits to highly placed

officials and, of course, for any of his recreational activities. He was also one of the few parents of mentally deficient children who persisted in his visits for quite a long period.

With the drugs we recommended and the general advice we could give, the boy actually showed some progress in his physical and mental development.

That a seemingly devoted father may not necessarily act in the child's interest only, but from rather distorted motives that aim more at his own security and welfare, is shown by the following history :

- (30) *Adarsh*, a Hindu girl from a city outside U.P., was brought by her father at the age of 10. A big, bulky head, prognathic teeth, squinting and short-sighted eyes, high palate, protruding ears, constant restless, twisting (athetoid) movements of the right hand, a deformity of the right foot, asymmetrical reflexes, badly articulated speech with a meagre vocabulary, lack of control over excretory functions, occasional convulsive fits and quite uncoordinated activity with any toy or test material, betrayed the dysplastic, brain-damaged idiot. A certain dullness and lethargy had been noted since birth, which had been delayed up to the 10th month of pregnancy. The child was breastfed up to the age of 2, learned to sit at 3, to walk at 4 and to talk a few syllables at 5. When she was aged 9, the parents tried to send her to school, but soon had to give up this venture.

The girl had 3 intelligent siblings, one elder, 2 younger, of whom the father seemed to be very proud. With regard to *Adarsh*, the father manifested a strangely inconsistent attitude : on one hand he showed great concern and boasted of all the trouble he had personally taken to teach the girl a few things, amongst them some practices of self-defence !—; on the other hand he seemed to resent the child and to be thoroughly fed up with her. The most subtle feature in his attitude, however, was betrayed by his statement that he could have had some very fine posts, even abroad, but that he had refused them in order to be able to remain with the sick child. His further arguments, when challenged about this strange renouncement of chances for promotion, made one guess that he himself was really afraid of climbing higher and of leaving the support of his family. The handicapped child provided a convenient scapegoat, which allowed him to represent as high-hearted and selfless fatherly devotion what in reality was only a timid catering to his own fear of being exposed and taxed beyond his level of maturity. This case was listed in the category of “inconsistent” attitude.

Amongst the cases which presented functional complications, the column for rejection is most prominent. A few of the cases listed in it have already been quoted. The following one may serve as a further instructive illustration :

- (31) *Sukhdev*, a Hindu boy from Lucknow, was brought to us at the age of 11, because of his mental backwardness. He looked far more like a child of 7 or 8. Physical examination revealed inflamed tonsils, a high palate, swollen lymphglands in the neck, breathing through the mouth, *genua recurvata et valga*. An asymmetry of the reflexes and of the tonus of the limbs made us suspect that, already before his premature delivery, the child had sustained some intra-uterine brain-damage.

Before Sukhdev was born, a first boy had died through getting accidentally drowned in a tub of hot water. The next child, a girl, died of typhoid, when the patient was aged $1\frac{1}{2}$ years. Then the mother had an abortion. During the pregnancy with the patient, her 4th, the mother vomited all through the 9 months. This makes one suspect that her attitude with regard to the child to be born was none too accepting. After his premature birth, the boy was too weak to suck the mother's breast and could hardly deal with the powdered milk he was given. Later, he was breastfed for 7 months. His development was very slow right from the beginning, and he was frequently ill. At the age of 2, when he was only just beginning to speak, Sukhdev got a younger sister, who was later followed by 3 more children, one girl and 2 boys. While, up to that moment, the mother's whole care, particularly after the death of the elder child, had been concentrated on the weak boy, as she wanted to save his life at all costs, her interest gradually turned to the healthier children, and she began to curse the patient as a tiresome burden and even expressed death wishes against him.

At the age of 11, he had been sent to first standard in school for 3 years, but had not profited much. He showed quite obvious signs of jealousy with regard to his younger brothers and sisters and frequently quarrelled with them.

In this case, premature delivery, possibly some prenatal brain-damage, a generally weak constitution, the contrast between early pampering and later open rejection by the mother, jealousy of his younger siblings, discouragement through the constant unfavourable comparison with them, and probably many other factors were involved. At the time when we saw the boy, it was difficult to decide, whether to label him as generally "infantile" or to assume a basic mental deficiency of mild degree, overlaid by neurotic features. He certainly showed some capacity for learning, when taught patiently and with some appeal to his childish imagination. Unfortunately, the parents were already too much discouraged to agree to the financial and emotional sacrifices which adequate treatment and education for the child and a change in their own attitude would have meant. After a few visits for special tuition and play therapy, he did not return. 3-4 years later, we happened to hear that the parents had consulted some other doctor, because, by that time, the boy, now at puberty-age, had begun to present serious behaviour problems.

The attitude second in frequency with regard to the children of the group combined with functional trouble is pampering.

- (32) The case of *Sudhir* may show us, what such parental overconcern can lead to. The 11 year old boy, eldest child and only son of a Hindu Kshatriya family, was born with a cleft palate. His inability to speak was regarded as a mere consequence of this malformation. Only at 3, when a corrective operation, unsuccessful a year before, had to be repeated, the surgeon pointed out that the child was mentally deficient. As the eldest son, he was the object of anxious concern and excessive attention of the whole family. Everything was always done for him without ever giving him a chance of trying out his own abilities. The result was that, though by the time we saw him, he was able to perform quite a few manipulations necessary for attending to his own needs, he would never lift a finger as long as anyone was there to help him.

The child, dysplastic and with signs of organic brain-damage, was certainly severely handicapped. But a good part of this inability to come up at least to a minimum of practical requirements, was obviously due to excessive pampering. If one has occasion to see, in some cases, with what joy and pride a mentally deficient child who has enjoyed proper care and teaching, will welcome any newly acquired skill and knowledge, one will certainly pity any child who, through the ill-advised overconcern of his parents, has been deprived of such healthy pleasure.

With these few examples, added to the ones already scattered throughout the previous paragraphs, we hope to have given a comprehensive picture of the parental attitudes and the way they can clear or block the way of a mentally deficient child. One will now realize that, often, the most promising field for any therapeutic efforts is that of parent-guidance !

(17) *Physical Defects* (Table XVI).—A physical defect of some kind or other was stated in 89.0 per cent of the oligophrenic children. 57.8 per cent presented neurological evidence of brain-damage, while in 73.4 per cent signs of some malformation were found. In quite a good number of children, dysplasia and organic brain-damage were combined.

Cases in which no physical signs of either kinds were noted, were most frequent amongst the morons (29.4 per cent), much rarer amongst the imbeciles (9.4 per cent) and completely absent in the group of idiots. This would support the view that the more severe cases of mental deficiency are less likely to be due to a simple hereditary variation in intellectual capacity as such, but more often associated with a disturbed embryonal development or some birth injury.

(18) *Former Illnesses* (Table XVII).—Western textbooks maintain that children with certain forms of oligophrenia are particularly susceptible to infectious diseases and often do not reach an age beyond childhood or adolescence. As here in India, severe infectious-illnesses are still quite frequent, one would expect that many of these children with an insufficient physical resistance might become victims of them. Our figures indeed show a fairly high incidence of typhoid, small-pox, pneumonia and

"other fevers" ; it is, however, exceeded by some of the figures for the other groups.

Considering the high rate of mortality amongst siblings, who may have had a similar constitution, we have to realize that the children we happened to see, were either those who had been carefully protected from contracting dangerous illnesses or who had been strong enough to come through them alive, while many others probably succumbed. Our figures can therefore in no way give any true picture of the incidence of infectious diseases amongst oligophrenics, nor of their resistance against such illnesses.

Infantile liver cirrhosis was signalled in 4 cases ; but again, this figure remains below the relative rates for some of the other groups, and there is no way of knowing, whether oligophrenic children are less frequently affected by this fairly common childhood disease, or whether those who actually develop it possibly have less chance of surviving than other children.

(19) *Education*.—In Table 6, we have tried to present, what attempts were made to teach the mentally deficient children. As one would expect, the only few children who managed to follow a school programme, at least for some time, are in the group of morons. None of these children, however, had attained the standard which would have been normal for their age. Even those who had advanced, had often just been "promoted", possibly on the strength of an influential father, as *e.g.* in the case of Anand (24), which we have described. The children in the group of imbeciles all seem to have failed to respond to the efforts of both, schools and tutors. One is rather surprised that even 3 of the idiotic children were subjected to probably quite inadequate educational experiments.

TABLE 6.

Educational Standard of Oligophrenic Children.

	MORON :		IMBECILE :		IDIOT :		TOTAL :		
	M.	F.	M.	F.	M.	F.	M.	F.	T.
Total cases in group :	15	2	23	9	10	5	48	16	64
No schooling attempted	2	—	15	4	9	3	26	7	33
School failure	3	—	5	3	—	1	8	4	12
Tutor failure	—	1	1	2	1	1	2	4	6
School and tutor failure	3	—	2	—	—	—	5	—	5
Sitting in 1-4th class	7	—	—	—	—	—	7	—	7
Sitting in 5-8th class	—	1	—	—	—	—	—	1	1

Though, in the absence of special schools for mentally deficient children, a tutor might fill a very useful function, he can hardly do so, unless he has a very particular knowledge of the capacities and needs of oligophrenics in general and the child entrusted to him in particular. Apart from this specialized training, a mental attitude of infinite patience and true concern for the child's welfare is needed for such work. Most teachers or students who offer their services for tuitions, have the sole ambition of proving themselves worthy of their fees by making the child, as quickly as possible, fit to spell out "a-ā", "i-ī", "u-ū" and to recite the arithmetic tables. We have seen children who, endowed with a good reproductive and mechanical memory, actually were able to achieve some such automatic performance, but without the slightest understanding for what they were doing. A child, for instance, may be able to count quite smartly up to 20 or higher, not only in Hindi, but also in English, but may lack the immediate concept of number even for as much as 3, or may not have grasped yet that counting a series of objects is a process of coordinating each number with each individual item. He may touch one object after the other and meanwhile recite his string of figures, without any correlation between the two acts and afterwards, quite proudly think that he really has accomplished the count. Similarly, a mentally deficient child, particularly if he has been inflated by parental ambition, may, with an important air, go through the motions of filling a whole page with signs that look like letters or figures or even have the configuration of written sums, but which do not make the slightest sense, as the child has never yet grasped that such performances, apart from pleasing the tutor or the parents, may have some meaningful correlation with anything in the world.

In teaching mentally deficient children,—and quite a few of them can be taught and enjoy learning !—one has to use methods that start from the children's natural interests and abilities and which remain close to concrete facts and therefore can continuously be built solidly into a widening mastery of the requirements of everyday life. Anything else is just false pretence, apt to frustrate, overstrain or unduly inflate the child. Unless schools or private tutors with such special methods are available, one had better leave hands off any attempts at "formal" education and limit oneself to training the child at home for a certain independence in taking care of his own needs. Placing a mentally deficient child into a class of normal children, will not only be unfair to the child, who suffers through constant comparison, possibly through teasing and punishment, but will also hamper the progress of those pupils who could profit by the teacher's full attention. One of the children we examined at the age of 14, was still attending first class for the 6th time. One can imagine, how deplacé a tall adolescent of that age will feel and how little chance of profiting he will have, if he is squeezed into a narrow bench between 6-7 year old children !

In some of the Western countries, with the cooperation of nursery school teachers all children of school entry age are "screened" by the school physician and the school psychologist for their physical and mental maturity to take part in the programme of an ordinary primary school. Those who, either at this preliminary stage or during the first few months of school-life, are found to be unfit, are referred to the special classes

which are attached to almost every government school. There, amongst their equals, the children find an adequate field for competition in developing their reduced abilities through practical experience rather than by any theoretical instruction or mechanical cramming.

It is heartening indeed to know that, recently, at least some small beginnings have been made in this respect here in India. It is to be hoped that experience gained in these first ventures will help to train people for further institutions of this kind, to be distributed all over the country. As we already mentioned, with the gradual spreading of literacy and higher education amongst the lower classes and the rural population, the problem of mental deficiency will be thrown more and more into the foreground, and parents will claim proper chances for equipping these children for an independent and useful life.

(20) *Problems of Adolescence.*—We have mentioned in the general part that the approach of physical maturity can create its problems, even if it is not accompanied by increased responsibilities and a widening of social contacts or, for girls, on the contrary, by restriction to the world of the “zenana” or the existence of an obedient daughter-in-law. We therefore can find particular problems of adolescence also in children who, as a consequence of their mental retardation, enter into the physical phase of puberty without being correspondingly developed in other respects. They have to face the rising instincts not only without having any understanding for their significance, but usually also with a considerable lack of conscious control. In boys, we may find shamelessly open masturbation ; the same may be observed in girls who, in addition, embarrass the family by their utter lack of concern and understanding for menstrual hygiene. As we have seen in one example (Asha, 22), girls without the necessary parental protection, with their lack of discrimination and inhibition and with their easy suggestibility, even run the risk of illegitimate pregnancy and possibly infection with venereal disease.

Lack of control over growing physical strength and tendencies towards aggression and forceful self-assertion, can create further problems. Particularly in boys, these may find an outlet in delinquent activities. Examples will be given in the special chapter on delinquent features. A few of the parents of severely disturbed children had already taken recourse to keeping them tied with ropes or even chains to save them from aggressive acts and indiscriminate roaming.

The wish to fulfil the traditional commands of “dharma”, may determine even parents of severely defective girls to arrange a marriage for them. This may at the same time be a convenient way of placing the burden for their future on someone else's shoulders. For boys, the risk of being pushed into a marriage seems to be smaller, as the parents of the prospective bride will probably take care to get information about his educational standard and occupational situation. Also their own families may realize that wife and any progeny would be a load on them. We have, however, amongst our adult patients, seen cases in which a healthy girl with normal intelligence and

quite a bit of sensitivity was negotiated into a union with an imbecile who could not even grasp the duties of a husband.

While, amongst our adult oligophrenics, the idiots had fortunately all remained without partners, 33.3 per cent of the moron group and 21.4 per cent of the imbeciles had been married. Amongst these, however, for 50 per cent of the women and for all imbecile men, the marriage had ended in separation ! All men of the moron group and the one imbecile woman, i.e. all those whose marriages lasted, had produced children.

The intention of getting an adolescent mentally deficient girl married, was expressed plainly by the parents of two of the girls in our group, while other parents may have harboured such hopes and intentions less explicitly.

- (33) *Mangalawati*, eldest surviving child of a Brahmin family, was brought to us on advice of the family doctor, at the age of 13. Physical examination showed dysplastic and organic signs. The girl, though physically mature, behaved like a child of 3-4 years and could not speak in proper sentences. She was restless, inquisitive and showed tendencies to run away and roam about indiscriminately. Though the father, being a teacher, should have known better, the parents' only ambition was to get the girl married as soon as possible.

One can imagine the fate of a girl of this kind, if husband and in-laws, behind a possibly quite well presenting outward appearance, should discover such gross defects immediately after marriage ! Not all parents might combine their strict adherence to "dharma" with so reasonable and kindly an attitude as the father of one of our grown-up patients, also a Brahmin. He quite calmly faced the prospect of taking his mentally deficient daughter back and looking after her for the rest of her life after concluding a formal marriage, just so as to satisfy his religious duties. If the parents regard marriage as a good opportunity for ridding themselves of a tiresome burden, a rejected daughter-in-law may well be in the pitiful situation of having no safe and peaceful place in this world either with parents or in-laws.

(21) *The Children's Interests*.—We present the table (Table 7) devoted to the children's interests, as it may possibly give some hints with regard to the point from which adequate training and attempts at schooling might profitably start. The fact that in 39 out of the 64 cases no interests were indicated, does not necessarily mean, except perhaps for the idiots, that the children were so dull or the parents so unobservant that there was nothing to report, but it may, at least partly, reflect the lack of completeness of our information on this subject. Even so, it may be instructive to see, what areas of interest were mentioned for the remaining 25 children :

We see from this table, that the interest most frequently mentioned is motor activity of some kind, i.e. running, walking, jumping, climbing, gesticulating or even dancing. A more passive interest in movement is manifested by those children who are

TABLE 7.

Interests of Oligophrenic Children.

	MORON:		IMBECILE :		IDIOT:		TOTAL :		
	M.	F.	M.	F.	M.	F.	M.	F.	T.
Total cases in group :	15	2	23	9	10	5	48	16	64
No interests indicated	6	2	14	8	6	3	26	13	39
Motor activity	4	—	3	—	—	1	7	1	8
Watching machines, vehicle	3	—	3	—	1	—	7	—	7
Fine clothes	4	—	2	—	—	1	6	1	7
Good food	3	—	2	—	—	—	5	—	5
Music	—	—	2	1	2	1	4	2	6
Noise	—	—	2	—	—	—	2	—	2
Playing with water	—	—	1	—	—	1	1	1	2
Manual occupation	1	—	1	—	—	—	2	—	2
Cinema	1	—	—	—	—	—	1	—	1

fascinated by vehicles and machines of any kind, either in merely looking on or in attempts at manipulating some mechanical device or being conveyed by a vehicle. We doubt, whether the frequently indicated interest in "fine clothes" may always have been an entirely spontaneous manifestation of the child's inclination, and not rather a reflection of the parents' ambition to cover up the child's ungainly appearance and clumsiness by smart outer coverings. Next in frequency, comes interest in music, which we even find in 3 of the idiots, 2 of them of the mongoloid type, while in 2 further children we find only a general delight in noise, even of a non-musical kind.

Motor performances and music are actually amongst the foremost activities that can be utilized in the first stages of teaching mentally deficient children. To train the ear to recognize different rhythms and pitches of sound, to coordinate the often awkward, overshooting motor impulses with these auditory stimuli, often provides the mentally deficient child with a first experience of being able to establish some kind of order and harmony in his chaotic or uniformly dull world. This experience cannot only establish a first step towards discipline, but it also creates self-confidence and joy in learning, which can be invested in mastering further performances. The possibility of discharging excessive, unruly energies in organized group-play, action-songs and similar activities, can furthermore reduce excitement to a level, at which mental concentration and

motor precision can be more easily obtained. From our tables, we see that only 2 boys, one moron, one imbecile, had reached a stage at which they could enjoy a more or less organized manual occupation. The only other interests mentioned are the most primitive one in food and, in one imbecile and one idiot, playing with water, while one moron boy showed pleasure in watching cinema performances.

We see that the range of interests in these children is very narrow, but that, even so, it might provide opportunities which, by a specialized teacher, can be utilized constructively in a way which will look like enjoyable play rather than frustrating drudgery to the mentally handicapped child.

(22) *Number of Visits and Possibilities of Treatment* (Graphs VIII and IX).—The number of oligophrenic children who were brought for more than one consultation only amounts to 40.6 per cent. Of these again, very few, only 3 boys and 2 girls, were brought for more than 3 visits. Partly this is explained by the nature of the illness itself, which does not give much scope for therapeutic measures of a purely medical or psychological kind. The main area of useful help to mentally deficient children lies in special schooling and later occupational training. What we were able to do, particularly for the children who came from far away, was often only to give the parents an honest estimate of the child's potentialities, to help them to correct any faulty attitude and, at times, to suggest some drug : either for stimulating a dull child or for calming an erethic one, or vitamins and roborants to improve general health. At times, treatment against intestinal parasites also helped to reduce excessive moodiness and occasionally even a tendency to convulsive fits.

While many parents were disappointed by our inability to perform magic miracles, others showed themselves grateful for even small signs of progress. One father proudly wrote that, after a few weeks of treatment according to our instructions, his little son had learned to peel monkey-nuts, while previously he had stuffed them into his mouth together with the shell ! In many cases, any improvement noted, may have been more a result of increased and better directed parental interest than of any specific drug action. Still, the reduction of excessive restlessness, improvement of motor and emotional control, which are within the scope of some of the modern drugs, may have its secondary effects on ability to concentrate and to learn. Certain other drugs, advertised as stimulating intellectual activity itself, may possibly influence a faulty amino-acid metabolism and improve the capacity for assimilation not only physically, but also mentally.

Again, however, we have to stress that, unless special schools and, for some cases, residential homes are available, no really effective help can be offered to the parents of mentally deficient children.

3. Postencephalitic States

(a) *Definition, Differential Diagnosis.*

The justification of setting up a separate group under the name of "postencephalitic states" can be seriously challenged from several points of view :

One may argue that, unless it is proved without doubt that certain neurological anomalies, emotional disturbances, motor handicaps and intellectual defects only arose after a definite infectious illness and that this illness had all the characteristics—clinical and bacteriological—of an encephalitis, one has no right to use the term “postencephalitic”. To this, we can reply that, under this heading, we have classified cases in which the disturbances noted by the parents started after some febrile illness associated with disturbed consciousness, often with convulsions and possibly with paralysis or lack of coordination of limbs and eye movements. In some cases, the illness was more of the type of meningitis. We must, however, admit that we have included some cases in which a febrile illness of this kind, occurring in early infancy, seems to have superimposed itself on an already existing brain-damage. In these cases, one has to assume that either the central nervous system, damaged by some other cause, *e.g.* by a degenerative process or by birth injury, was more susceptible to later infection or that already the congenital defect may have been due to an intrauterine virus infection which, after a period of latency, may have produced renewed acute manifestations, either through increased virulence of some persisting germs or through an allergic sensitization.

Summaries of current literature [Excerpta Medica (19)] which were consulted, did not provide much help in deciding the question, whether these states should be classified, together with more definitely known cases of exclusively postnatal encephalitis, in this separate group. A certain confusion and uncertainty with regard to classification is obvious throughout literature. There seems to be some consensus of opinion that encephalitic processes occur, not only as a well defined separate morbid entity, but also in association with virus and bacterial infections of a general type and sometimes even in a mild, subacute form which may not be recognized as such, but may all the same leave permanent consequences. Furthermore, it seems to be accepted that some such infections can take place during the embryonal period and thus be responsible for congenital defects. Other authors prefer not to commit themselves too definitely to diagnosing an infectious origin and speak more vaguely of “childhood encephalopathy” (*i.e.* unspecific disease of the brain). Then again, one finds the term “cerebral palsy” applied either only to consequences of encephalitis, or then selectively to any disturbance of the nervous system which, possibly amongst other consequences, produces motor impairment, no matter whether this is due to an infection or to tumors, injuries or a degenerative process. On the other hand, there is a tendency to categorize as oligophrenia any state, either congenital or early postnatal, which is characterized by an obvious mental defect. We thus seem to have classifications according to aetiological, in particular bacteriological criteria, others according to symptomatology in a very wide sense, and further ones delimiting syndromes with quite specific features. Finally, one can classify according to the time of origin : prenatal, early postnatal and later in childhood, adolescence or adult life. Seeing this lack of a definite system, we feel justified in grouping some of our cases under the heading of postencephalitic states, even if we might run the risk of including an occasional case which may not strictly deserve this name.

One will remember, that we had already included in the oligophrenic group a few cases in which we assumed that a congenital mental deficiency had been complicated by a later attack of encephalitis. We cannot exclude that some of these cases might have been better placed primarily into this present group of "postencephalitic" children and that, on the other hand, some of the "postencephalitic" children might perhaps just as well fit into the category of oligophrenics with later complications.

The main reasons why we want to keep the group of postencephalitic states separate, are the following : First of all, an observer from the West is impressed by the frequency of brain-damage due to infectious processes amongst children here in India. These states therefore deserve special attention with regard to preventive measures in the form of vaccinations and adequate treatment during febrile illnesses, as well as with regard to special therapeutic necessities, once any permanent consequences have developed.

A delimitation against oligophrenia, though perhaps the line cannot always be drawn with certainty, seems indicated, as many of the postencephalitic children are not in first line impaired by an intellectual deficiency, but rather by motor handicaps and lack of emotional control, which, of course, can have a secondary effect on intellectual functioning. This distinction again might point to therapeutic possibilities slightly different from these applicable to a primary mental defect.

On a merely intuitive level, one sometimes is affected differently by a genuinely mentally deficient child and one mentally handicapped by some secondary brain-damage. While, in the former, one simply registers the absence or very weak presence of a human mind with which one could communicate, one sometimes feels, in the latter, that some more differentiated human consciousness is there, but imprisoned, rendered ineffective and out of reach, by a body that lacks intact channels for its expression.

Though some of the children classified in this section may not have achieved a higher intellectual development than many of those in the oligophrenic group, one will see, in the table on "education" and the one on "interests", that the group as a whole shows a higher standard than that of oligophrenics.

Another problem is the limitation of the postencephalitic group against that of epilepsy. Many of the children had convulsive fits. Again we followed the practice of only labelling as "combinations" with epilepsy those in whom the incidence and regularity of fits went beyond a few occasional ones during fevers.

A delicate diagnostic task was the differentiation between postencephalitic behaviour disorders and infantile psychosis. As many authors maintain that certain forms of infantile autism are the consequence of early brain-damage, one can perhaps assume, as we had hinted earlier, a kind of sliding scale with organic damage and negligible emotional factors at one end, and emotional influences acting on a healthy

nervous system at the other. Where one wants to draw the dividing line between "infantile psychosis" as a functional group and "autistic features in brain-damaged children", will have to be left to the discretion of individual observers and authors. We have already mentioned that our group of infantile psychosis contains some brain-damaged children. In our group of postencephalitic children, on the other hand, we have noted obvious autistic features in at least 4 out of the 35 cases. As, however, the presence of these features was not the dominant component in the total picture of the illness, we have counted these children in the combined group of "postencephalitic state with neurotic superstructure". We shall have to come back to these few cases, when the group of infantile psychosis is discussed in detail.

The question of differentiation between postencephalitic states and more adult types of psychosis, did not arise in our material. It plays, however, a certain role, perhaps again in the form of a kind of "liding-scale", amongst our adult patients.

Some of the adult cases, in whom the acute attack of encephalitis seemed to have occurred at a moment of emotional crisis, which somehow had to find its expression in some symptom, even pose the problem, whether a kind of psychosomatic readiness might open the door to infection of the central nervous system or whether, at least, an underlying emotional tension might fix and exacerbate postencephalitic symptoms that promise to be of use in solving a conflict or in erecting a defensive wall against it. The fact that, in our material, both amongst the adults and the children, the incidence of functional psychiatric disturbances in the family is higher than any heredity of the "congenital-organic" type, also makes one wonder, whether a particular sensitivity of the central nervous system may at the same time expose person not only to a physical invasion by germs, but also in an increased measure to disturbing emotional influences. In other words, one might suppose that the so-called "neuropathic" children, who tend to abnormal emotional reactions and developments, may also more easily fall victims to infections of the brain, so that any final result might present a mixture of organic and functional features.

Such considerations, far from neatly solving our problem of a consistent classification, merely remind us once again that any separation of organic and functional, body and mind, will always be setting artificial limits and that, ultimately, we have to think in terms of a psychosomatic unity.

(b) Causes and Origin.

By definition, the cause of the disturbances in the group under discussion is an infection of the brain by virus or bacteria. In some cases, the pathological process may not consist in direct local action of the micro-organisms, but rather in an allergic reaction against toxins, which can have a destructive effect on nervous tissue.

As already mentioned, the brain can be affected by encephalitis as a separate morbid entity in its own right, or as a complication of other infectious diseases, like small-pox, chicken-pox, measles, whooping-cough, parotitis epidemica, typhoid and other diseases of the Salmonella group, influenza and certain types of pneumonia. In our material, we were not always able to trace the exact nature of the illness that had produced the symptoms. In some cases, it seems to have been virus encephalitis, in others small-pox or typhoid, in one case possibly cholera. Complication of small-pox vaccination seems to have been responsible in 3 cases and anti-rabies injections in another one. It might be instructive to sum up two of these cases :

- (34) *Girish*, second of 3 children of a Brahmin family, developed normally up to the age of 8 months. Then, after small-pox vaccination, he had high fever and was unconscious for 3 days. Convulsions, which first occurred at that time, were repeated during/ later febrile illnesses. The parents maintained that, according to the doctors, the child also suffered from typhoid, pneumonia and meningitis. So we do not quite know, whether the vaccination alone is to blame or whether, by some unlucky chance, it may simply have fallen into a period when he was incubating some other disease. After this severe illness, Girish lost his hearing power, which, before, had definitely been developed. He only learned to walk at the age of $4\frac{1}{2}$ years. When we examined him at the age of 7, he could only hear very loud noises and produce a few inarticulate sounds. He behaved like a very small child, sucking his fingers, hardly recognizing his surroundings, and quite incapable of even announcing his toilet needs.
- (35) *Jehan*, daughter of a Muslim tailor who, up to the age of 7, had been a healthy, sociable and intelligent child, was bitten by a dog and given a series of anti-rabies injections. 3 weeks later, she started having convulsive fits and, associated with them, states of unconsciousness, sometimes lasting several days. She deteriorated mentally and became dull and stubborn. When we saw her at 14, her limbs were spastic. On her head, one noted numerous scars from falls during fits. She only uttered a few scared, inarticulate sounds. The fact that in the family 7 out of 16 children had died in infancy, may mean that some particular weakness of the nervous system had been inherited.

In 4 cases, the illness that had set off the symptoms, had been labelled by the doctors as meningitis. The consequences noted, however, seemed to indicate that not only the wrappers, but also the substance of the brain had been involved in the pathological process.

- (36) *Pappu* was a foundling child who, from early infancy, had been brought up in a children's home. His huge head, the squinting eyes, the slackness of his limbs, the mental backwardness and emotional dullness were unmistakable signs of a meningitis, sustained probably soon after birth. In spite of this severe defect, there was something appealing in the child's gentle smile, so that a childless widow decided to adopt him, when he was aged about $2\frac{1}{2}$. Already after a short

time, however, the foster-mother brought the child back to the home, as his inability to respond to her emotional needs had disappointed her. In this case, it would be difficult to decide, whether his lack of attachment was entirely due to the organic defect or perhaps partly a result of very early neglect.

- (37) *Ahmed*, a Muslim boy from Eastern U.P., was ill with some fever and "liver trouble" at the age of 6 months. The doctor suspected tuberculosis and treated him accordingly. At the age of 18 months, though still weak and apparently suffering discomfort, he was declared cured. At the age of $2\frac{1}{2}$ years, he started having convulsions and became blind and deaf. During 8 months, he was treated at a hospital with antitubercular drugs, frequent lumbar punctures and careful nursing. He was partly paralysed and so weak, that for some time he had to be tubefed. When the child was brought for consultation at the age of 4, he was blind, hard of hearing unable to speak and quite generally retarded in his development. At times he had fits of temper, in which he would bite and beat anyone who came near. Most of the time he was wagging his big head in rhythmical fashion. When left with toys, he would not try to reach out for anything. Objects that were put into his hands, were immediately led to the mouth.

The concerned parents, who had lost 3 of their 9 children at an early age, still had hopes that the poor child might regain his full health. His pitiful condition seemed a poor reward for all the patient care that had been spent on keeping him alive.

Until about 15 years ago, children with tubercular meningitis were invariably doomed to death. The modern antibiotics allow to save the life in many cases, but often leave the child sadly crippled physically, mentally and emotionally.

Congenital brain-damage, possibly already of infectious origin, but at any rate later reinforced by some febrile illness, seems to have been responsible for the disturbances in the following case :

- (38) *Rameshwar*, younger of 2 surviving children and only son of a Hindu merchant, was brought to us at the age of 5. The parents were worried about his retarded development, his motor restlessness, his impulsive, mischievous and at times destructive and aggressive behaviour.

The slim, agile little boy was quite friendly and affectionate, but could only utter some inarticulate sounds. The history given by the parents indicated that the pregnancy had been disturbed by imminent abortion. The delivery took place about one month before term. Since birth, the boy responded less than the other children in the family.

At the age of 6 months, during a febrile illness called "pneumonia", he manifested, for the first time, some jerking of the body on waking up from sleep. At the age

of 2½ years, he again went through an illness with high fever and, this time, had full-blown convulsions. Isolated fits again occurred during later febrile illnesses. The restless, mischievous behaviour of the child seemed much more typical for a postencephalitic disturbance than for a mere mental deficiency.

Rameshwar's parents were remarkably persistent in bringing the child for observation and advice. With suitable drugs, his motor agitation could be reduced considerably, so that he became more capable of fixing his attention and of learning something.

A case with a late start, and in which virus encephalitis had been diagnosed, not only on the basis of clinical symptoms, but also by analysis of blood and cerebrospinal fluid, is the following :

- (39) *Gopal*, second child and only son of a Hindu doctor, who had developed normally up to the age of about 4, manifested some convulsions during tonsillitis with high fever. After this incident, he was treated for intestinal parasites. At the age of 4½, he again had fever and convulsions and was so ill, that one hardly expected him to survive. For 6-7 days, he was delirious and his body was frequently shaken by jerks. Pressure and cellcount of the cerebrospinal fluid were increased. Under appropriate treatment, which for the son of a doctor was of course easily available, he recovered fairly well within 2 months. The parents, however, watched any further improvement rather impatiently and were not satisfied, when, 6 months after this severe illness, the child still showed some lack of coordination in his movements, urinary incontinence and some behaviour disturbances, such as fits of anger and aggression, abusing, spitting, reluctance to study. Neurological signs of brain damage were obvious.

At the moment of consultation, only 6 months after the acute phase, one could not estimate, how important any permanent damage might be, nor could one decide, whether his disturbed behaviour was entirely due to organic causes or whether the overdemanding attitude of the parents with regard to this only son had already started to exercise its harmful effect.

A certain regression to a more childish stage can often be seen in the period of convalescence after a serious illness, even if the brain has not been directly affected, and a child has to be given time to regain confidence. An attitude of patience and helpful encouragement is necessary even then, and all the more, of course, if a brain-damaged child has to learn to make the best of his remaining abilities.

One case, in which we were rather at a loss, whether to classify it as postencephalitic or epileptic, presented features of an acute infectious process in the central nervous system, at the moment when we examined him :

- (40) *Pratap*, aged 15, was brought in a state of high fever, pulse racing at 160 per minute, confused and delirious, complaining of violent headaches and at times talking about seeing strange visions of Gods or some old man and woman standing near.

While already for the last 3-4 years, after typhoid, the boy had had occasional convulsive seizures, he had, during the last 6 months, gone through several attacks similar to the one we witnessed : high fever, confusion or unconsciousness and, as the family called it, "insane behaviour with religious visions". Some of the attacks had only lasted a few days, others up to 2 weeks. The presence of a slight atrophy of the right leg, made us suspect that, apart from the acute process and any damage already sustained in connection with the attack of typhoid some years before, there may have been some congenital lesion, which predisposed the boy to later encephalitic attacks.

We referred the boy for the necessary physical investigations and treatment to Medical College.

(c) *Combinations.*

The case just mentioned and one similar one, though not with acute symptoms, were counted as combinations with epilepsy, as the connection between the convulsions and the symptoms indicating encephalitic damage was not quite clear.

Four further cases have already been classified as combinations of oligophrenia with later addition of postencephalitic features, two of them complicated with neurotic superstructures.

The only combined group that remains to be characterized, is that of 9 children who reacted to their handicaps or to the attitude of the family, with psychogenic distortions. It is, of course, not always easy to distinguish any functional overlay from the basic trouble, which often manifests itself in the form of behaviour disorders. Often, the diagnosis had to be made less from the observed symptoms than through our knowledge about harmful parental attitudes and other environmental influences that were likely to have added their effect to the original trouble.

We have already seen in the case of Gopal (39), which was seen 6 months after the acute phase of the illness, how important the parents' attitude during the first phase of recovery can be. While in Gopal's case, the parents' overambitious pushing threatened to impair his further convalescence, the following case is an example for functional complications due to excessive pampering :

- (41) *Krishan*, a 14 year old Baniya boy from a city outside U.P., had been an intelligent, healthy boy up to the age of 6, when he suffered from meningoencephalitis. He came out of this illness with some lack of motor coordination and an impairment of his intellectual functioning. In their overconcern, the parents spared him any effort, any frustration and even any well-earned criticism or scolding. At the age of 14, when we saw him, Krishan, tall and with signs of physical maturity fully developed, had become the tyrant of the whole household. He had full command over all servants who, on the parents' orders, had to treat him as the big "Saheb", and he was free even to threaten his tutor. Though by that time an occasional checking or admonition had become highly necessary,

any criticism sent him into violent fits of rage. Having grown used to obtaining everything without effort, he had not taken any care to learn, though he had the benefit not only of a private tutor, but also of visiting one of the rare special schools for handicapped children. His whole behaviour was that of a spoilt, irresponsible child, contrasting strangely with his physical maturity.

Further examples of functional superstructures will be given later, as illustrations for other factors.

(d) *Characteristic Features in our Material.*

(1) *Distribution according to Sex.*—The ratio of 2.5 boys to 1 girl shows a somewhat smaller divergence between the figures for the two sexes than in the group of oligophrenics, where the proportion was 3 : 1. Girls are even more frequent, almost reaching a proportion of 2 : 1, amongst those cases in which the attack of encephalitis occurred late in childhood and without any previous defects. It is natural that parents should be more ready to seek help, even for girls, in cases that had initially enjoyed a normal development and in which a dramatic phase of illness had brought about the change, than for a child who may have shown signs of physical handicaps and mental retardation right from birth.

(2) *Distribution according to Age.* (Graph Ib). Again, as in the age pyramid for the oligophrenic group, we find an accumulation of cases, at least of boys, at the age of 7-8, when school entry becomes a burning problem. Apart from this irregularity, the rest of the graph shows a fairly uniform distribution over all ages. In particular, we note no significant broadening out of the columns for adolescent age.

In contrast to the oligophrenic group, the onset of disturbances in the postencephalitic group may have been at any time between earliest infancy and the actual age at which the child was brought. One would therefore expect that the age-distribution in this group should not be so much influenced by social factors, but rather by the onset of the illness itself. In fact, quite a few of the cases, some of them already quoted, were seen within a few months of the acute febrile stage, probably as soon as the parents realized that some damage would persist.

(3) *Reasons for Consultation and Main Symptoms* (Table IV).—The main reason for consultation was more often a behaviour problem than a mere intellectual defect. 31 out of 35 children, i.e. 88.6 per cent, worried their parents by lack of emotional control or some similar disturbance, while only 71.4 per cent of the children were found lacking in their intellectual performance. An equal number, i.e. also 71.4 per cent, had, at one time or other, mostly in the acute stage, been the victims of convulsive seizures. Motor handicaps, experienced as such by the child or obvious even to a non-medical observer, were only indicated in 48.5 per cent of the cases, while signs of localized brain-damage were found on detailed neurological examination in 80 per cent of the cases.

One may have expected that some motor disturbance or at least neurological signs of brain-damage should have been present in all the children. One knows, however, that, in contrast to adults, in whom the postencephalitic syndrome is usually characterized by extrapyramidal motor symptoms, like rigidity, tremor, tics, children often react to the brain-damage set by an encephalitic process, probably in the diencephalic centres that regulate emotional control, predominantly with behaviour disorders. Above all, one notes a constant restlessness, lack of concentration and mischievousness that often give the impression of wilful wickedness rather than of an organic disturbance. It therefore need not surprise that, in some cases, in which the previous history justified this, we assumed consequences of an infection of the brain without finding any neurological evidence of localized damage.

(4) *Local Origin* (Table III).—62.9 per cent of all children of this group were brought for consultation from outside Lucknow. This, and perhaps also the fact that, with 8.5 per cent, the number of children brought from villages is higher than in any other of the congenital-organic groups, may again allow us to assume that, for a handicap which is so obviously the direct consequence of a well defined physical illness, parents, even villagers, are more ready to seek medical help than for a congenital state or for a disturbance which is supposed to be the result of possession by evil spirits.

No refugees or foreigners are to be found in this group. Migration and frequent absence of the father seems to have had some effect on one boy :

- (42) *Jai Raj*, aged 11, eldest of 4 children, was mentally retarded since the age of $2\frac{1}{2}$ years, when he suffered from high fever during measles. It is, however, possible that he may already have had some defect at birth. As he was the eldest child, the parents only realized that he was developing abnormally, when they were able to compare him with the next-born child. At the age of 3, he had some convulsive fits.

On examination, we found spasticity of the left arm and leg-general lack of motor coordination, in particular an unsteady gait. Some bony deformations seemed to be due rather to rickets than to any congenital dysplasia. Though his speech was indistinct and his whole behaviour rather clownish, he apparently had some ability to learn. The father, however, a soldier from a scheduled caste, was the only person in the family who had sufficient patience and concern to teach him. The mother, immature and short-tempered, was thoroughly fed up and preferred the short route of simply doing the necessary for the child to investing patience and kindness in encouraging him to greater independence. Consequently, whenever the family could not follow the father on one of his frequent transfers, the child regressed, while, under the father's care and guidance, he was able to develop what abilities were left in him.

(5) *Community and Caste* (Graphs II and III).—Except for the absence of Sikh children, a slightly higher rate of Muslims and one Parsee child, the only one in our

whole material, the distribution of religious communities in the postencephalitic group does not differ much from that amongst oligophrenics :

As to the Hindu castes, we again see, even more distinctly than amongst the oligophrenics, a predominance of Brahmin children. Possibly the same reason we tried to give for this phenomenon in the previous group may also apply to postencephalitic children, *i.e.* a greater sensitivity and perhaps a reduced tolerance for deviations in children's behaviour and intellectual performance, and consequently a greater readiness for seeking help, amongst Brahmin families. The percentage of Shudras is more than twice as big as in the oligophrenic group, again perhaps a sign that mental, emotional and physical disturbances arising in a previously healthy and normal child may provide stronger motives for consulting a doctor, even to little educated parents, than a congenital handicap.

(6) *Occupation of Father or Guardian* (Graph IV).—The same reflection may be valid with regard to occupational classes : farmers, labourers and craftsmen together account for 11.4 per cent of the children, while amongst the oligophrenics this rate is only 7.8 per cent. The share of children from fathers in academic professions and high positions in service, compared with other groups, is relatively high, if we consider that in the total population this group is hardly likely to exceed the sectors of business and service. A similar distribution is only found in the group of infantile psychosis. Again we may have to assume that families with a high educational and cultural standard may accept a child's handicap less easily and, of course, at the same time be more enlightened about the possibility for help and financially more able to afford it.

(7) *Joint and Individual Family* (Graph V).—The percentage of children who were known for certain to come from joint families, with 12.5 per cent, is more than twice as high as that amongst the oligophrenics. Again, however, we find this rate, with 18.2 per cent, even higher amongst the children in whom the postencephalitic disturbance was complicated by neurotic features. In the small number of these children, we find a contrast between the attitudes of various family-members : either the parents are pampering, while other relatives disapprove of this attitude and would like to subject the child to more discipline, or the parents themselves are fed up, while some grandmother or aunt takes the child's side. In both these situations, even a brain-damaged child will know, how to take his advantage and thus may escape from any consequent training.

(8) *Lack of Parents* (Table VI).—With regard to lack of parents, the group of postencephalitic children, with a figure of only 5.7 per cent who had to miss full parental protection, seems to be particularly privileged. Apart from the one foundling child already mentioned (Pappu, 36), only one boy :

(43) *Vishvanath*, had been deprived of his father, when he was aged one, already one year before a febrile illness, probably virus-encephalitis, left its marks on him. The boy, youngest of 3 surviving children, was well cared for by his mother and showed no signs of a superimposed functional disorder.

(9) *Heredity* (Tables VII and VIII).—The total rate for psychiatric morbidity amongst the relatives, as one would expect it for a group of children with an acquired illness, with only 28.6 per cent, is much lower than that for oligophrenics.

What one might perhaps call a "specific heredity", *i.e.* the incidence of organic affections of the central nervous system amongst relatives, only amounts to 8.6 per cent, *i.e.* just half of the figure for "specific heredity" amongst mentally deficient children.

The highest rate for any single psychiatric disorder amongst relatives is that for neurosis and psychosomatic diseases, which amounts to 17.1 per cent. We have already previously ventured the assumption that a so-called "neuropathic constitution", *i.e.* a particular sensitivity of the central nervous system and its connection with the vegetative nerves, may possibly dispose members of the same family either to neurotic reactions or to cerebral localisation of infectious diseases. In contrast to all other congenital-organic groups, the proportion of congenital-organic to functional psychiatric affections amongst the relatives, with 1 : 1, 3, is weighed down more heavily on the functional side.

Parental heredity (Table VIII) equally, with 17.1 per cent, shows one of the smallest rates of all groups. The biggest single item which contributes to this figure, is the incidence of neurosis in the mothers of 3 children.

Early death of siblings (Table IX) had occurred in 37.1 per cent of the families of postencephalitic children, reducing the total number of all children by 18.3 per cent. Both these figures are on the lower side compared with other groups. We have already given one example of a family (Jehan, 35), in which 7 out of 16 children had died.

While in this group there are no children whose parents were also amongst our patients, there are 2 families out of whom we got to know more than one child :

- (44) *Naheed* and (45) *Masih*, a girl aged 9 and a boy aged 4, were brought at the same time by their father, a Muslim teacher, from a small country-town of U.P. Both children had developed normally up to 1958. At that time, 3 of the 5 children in the family were attacked by small-pox. One girl, aged 2, died, while *Masih*, aged 1, and *Naheed*, aged 6, though paratyphoid added itself to the initial disease, survived, but were handicapped by lack of motor coordination, shaking of limbs and mental retardation. Some time later, both children also started having convulsive seizures.

When the children were examined by us, 3 years after the acute illness, both presented obvious signs of organic brain-damage. The 4 year old boy was small and underdeveloped, heavily pock-marked, unsteady on his feet, saliva dribbling from his mouth continuously. He had learned to speak fairly well, but was exceedingly shy and anxious.

In his elder sister, we noted some spasticity of the left arm and leg. She too was very timid and scared and seemed to be afraid of her own movements. In both children, motor inhibition, stiffness and lack of coordination seemed to go far beyond what one would reasonably have expected in view of the organic damage evident on neurological examination. The father's own worrying and the account he gave of the mother's restricting overanxiousness, made it plain that both children had been kept back from healthy exercise for their handicapped limbs, while intellectually they had been excessively driven by the ambitions of a father who still hopefully planned a brilliant career in an English school for his little son.

In this case, brother and sister had not only been exposed to the same risk of infection, but also to the same restricting and overanxious parental attitudes ; possibly, in view of the mother's neurotic behaviour and the father's rather sensitive nature, they may also have inherited a particularly delicate nervous system. Of a further couple of siblings, Hindu, only one belongs to the group of postencephalitic children :

- (46) *Sheila* was brought to us on the initiative of her eldest brother, a student aged 22, who had been a regular psychotherapy patient at our Center for several months. While this young man's trouble was predominantly of a psychosomatic nature, it was known that one paternal cousin was suffering from mental deficiency. After the birth of the eldest brother, 2 sisters had died in infancy. A next brother, 5 years older than Sheila, was living and, as far as we know, free from physical and emotional trouble. A further brother died soon after birth. Sheila, the youngest, was born on term after a normal pregnancy and presented no defect. At the age of 8 months, after an attack of small-pox, she became weak and, for some months, had convulsive fits. Her hearing power was also impaired temporarily. She never learned to speak properly, but used some kind of private baby-language in conversing with herself. The parents had noted that she seemed to be particularly interested in smelling dirty things. She was very choosy about food, but, on the other hand, even at the age of 12, would occasionally swallow indigestible objects, as e.g. coins or small toys. At times she went into temper tantrums and beat herself. She did not seem to be emotionally attached to anyone except her mother. We ourselves noted a rather small head and increased reflex responses in the arms. The girl frequently performed sniffing, smacking and sucking movements, as they are typical for lesions of certain central parts of the brain (rhinencephalon). Her movements were quite agile and graceful, and she played skillfully with some of the toys offered and was even able to perform simple tests.

One got the impression that much of her behaviour had been moulded by the same environmental influences that had also distorted the eldest brother's emotional development. He too seemed to have been, in his childhood, a victim of excessive pampering as far as physical requirements were concerned, while no

one had any understanding for his emotional needs. Sheila had obviously been pampered in earlier years : but the parents seemed to be thoroughly fed up with her and openly uttered death-wishes, by the time we saw her.

Sheila is one of the children in whom we registered autistic features, particularly her lack of attachment to anyone and her use of "private language" to herself, while, for communication with others, she would not use speech.

When there was an opportunity of again seeing the girl about 5 years later, when she had grown to an age of 17, it was obvious that some brain-damage played a decisive part in her abnormal development. On the other hand one could not quite exclude that the family atmosphere, which had affected the elder brother's emotional growth, might also have had a harmful effect on this youngest and only daughter by preventing her from making the best of her poor potential and by favouring emotional distortions in addition to the organic handicap.

(10) *Number of Siblings and Special Positions in the Sibling-Row.* (Tables X and XI and Graph VI).—Families with more than 6 children, both born and surviving, are much less frequent in the group of postencephalitic children than amongst the oligophrenics. The average number of children surviving per family is only 3.9 per cent.

Special positions amongst the surviving siblings exceed the maximum possible rate significantly, by 12.9 per cent, only in the small group of postencephalitic children with neurotic superstructures, while, for the group as a whole, the number of special positions, with an excess of only 0.8 per cent, practically corresponds to the rate as it would be, if all children had been exposed to similar risks of contracting the illness. This certainly enhances the assumption we made for the oligophrenic group, *i.e.* that the chances of being afflicted by one of the illnesses of the congenital-organic group are probably fairly independent of a child's position in the sibling-row, but that any unique position increases the probability that a handicapped child of this group will develop some functional complication.

Amongst the cases quoted, we have already presented some instances of "special positions", Jai Raj (42), an eldest son, Gopal (39), an only son, Rameshwar (38), youngest and only son.

As the one position which exceeds the expected maximum most considerably, by almost 50 per cent, is that of the eldest or only child, we shall offer 2 more examples of these positions :

(47) *Kiran Bala* was the only child of a clerk in the Army. She was brought from one of the big towns of U.P. on advice of the family doctor.

After a difficult forceps-delivery, the child showed no major defects, but developed somewhat slowly, learning to sit only at the age of 10 months. When she was one year old, she had an attack of high fever with convulsions. When, some time later,

she was vaccinated against small-pox, she again went into a series of convulsions, lasting one week. Isolated further fits occurred, whenever she had a febrile illness. After the illness which first provoked the seizures, development was even more retarded. She learned to walk at 2 and started talking at 3. Even at 10, however, when we examined her, she could not speak properly. At the age of 7, she was sent to school and was pushed up to 3rd class, without, however, having even mastered the simplest elements of the first class programme. Up to the age of about 9, she had been bedwetting.

The delicate girl looked much younger than her age. Asymmetry of tonus and reflexes betrayed the organic brain-damage. She refused to cooperate in the physical examination and went into a fit of screaming and making herself stiff all over. She kept anxiously clinging to her mother, who would tolerate all the fuss up to a certain limit and then suddenly go into exasperation, calling the child "dirty" and "naughty" and threatening to leave her, an instructive example of inconsistent parental attitude ! The father seemed to be quite concerned about his little daughter, but, just as the mother, tended to lose his temper, when his patience was stretched beyond a certain point.

It is difficult to say, in this case, how far the child's anxious, clinging behaviour was a direct outcome of the organic affection and how far, perhaps under the influence of the parental attitude towards this only child, her disabilities had been accentuated by emotional factors.

- (48) *Ranjit*, aged 14, was the first born of 4 children of a Brahmin family. Up to the age of 8, this eldest son, above average in school, was the pride of his parents. Already at 6, during a fever, supposed to be typhoid, he was unconscious and confused. Two years later, at 8, during a febrile illness, his whole right side became paralysed and he lost the power of speech. He gradually recovered to a certain extent, but only learned to walk again with an orthopaedic boot one year later.

At the time when we examined him, we noted signs of spastic hemiplegia with an athetoid component on the right. The cerebral nerves also were involved, and the paralysis had also led to trophic disturbances in various parts of the body. He walked with difficulty and spoke with a stammer. He could write with the left hand.

The parents complained about his irritability, his loss of temper, when his wishes were crossed, his shyness and occasional depressive moods. No one seemed to realize, how much courage and determination he had been investing in overcoming his severe handicaps. In spite of his difficulties, he had reached 9th class at the age of 14. He had learned to play chess and he had even set himself the aim of becoming a lawyer. While his younger siblings and his comrades in school showed themselves helpful, his parents resented that he had

not progressed even further and that he could not be relied upon for performing his physiotherapeutic exercises for the paralysed limbs without help and admonishment.

Though this boy did not show any manifest signs of neurotic distortion, unless his occasional depressive moods and fits of temper can be considered as such, it is obvious that his position as the eldest son exposed him in an increased measure to parental expectations and ambitions.

(11) *Age of the Mother on Birth of the Child* (Table XII).—The figures for both, young and old mothers, remain behind the average of our total group of children and do not seem to have any particular correlation with the disease grouped in this section.

(12) *Complications of Pregnancy and Delivery* (Table XIII).—Complications of pregnancy (11.3 per cent) and delivery (20 per cent) occurred somewhat more frequently in this group than the average calculated for all children. We have already presented a few cases in which premature birth or forceps delivery may have created a "locus minoris resistentiae", facilitating the intrusion of pathogenic microorganisms into the central nervous system at a later stage.

(13) *The Period of Breastfeeding* (Table XIV).—Only 4 out of the 35 children were breastfed beyond the second year. All of them are either youngest or only surviving children. In 3 of them, the encephalitic attack occurred before breastfeeding had been stopped. So, as we tried to show for the oligophrenic children, their helplessness and dependence may have provided an easy chance for maternal clinging.

It may be interesting to note that none of these 4 children was counted amongst the group with neurotic complications. Possibly, at a stage of regression after a severe illness, maternal devotion that might have done harm by excess to a healthy child, suited the needs of these handicapped children.

(14) *Toilet Training*.—Approximately 1/3 of the children in the postencephalitic group were unable to control their excretory functions. Most of them had been attacked by the handicapping illness in infancy, before toilet training had been achieved. There are, however, also a few cases in which an already acquired control was abolished by the illness.

It would be difficult to say, even in individual cases, whether the incontinence can be regarded as a direct organic consequence of damage to the nervous system or merely as a sign of general regression after a severe illness or possibly as a neurotic symptom, perhaps of protest against a parental attitude. The parents, in most cases, did not seem to regard this lack of cleanliness so much as a behaviour problem, but rather as a sign of reduced intellectual powers.

(15) *Early Neglect*.—The mothers of 2 of the children in this group fell seriously ill shortly after delivery, and therefore were not able to take care of the baby. The one mother, who had a physical illness, seems to have made up later for the initial lack of care by breastfeeding the boy up to the age of 3. The other case is to be quoted here :

(49) *Joya* was the third daughter of a Christian family from Bengal. After her delivery, the mother, an educated woman, developed puerperal psychosis and, of course, could not be entrusted with the child. Apparently, she recovered fairly quickly ; but we know that the girl was only breastfed for 3 weeks. At the age of 11 months, Joya had whooping-cough and pneumonia with high fever. She was unconscious, had convulsions and remained blind, deaf and paralysed on the left side for some time. Gradually she recovered sight and hearing, but remained mentally retarded. At 9½, she still could not eat alone, had not learned to speak, and at times went into fits of destructiveness. She could be quite lively, curious and inquisitive, but started crying anxiously, as soon as she met with any obstacle in her activities. At such moments, she would cling to her mother, on whose help she was completely dependent.

After Joya's illness, the mother provoked abortion in two further pregnancies, though there was no boy in the family yet. Her explanation to us was, that the birth of another child would not have allowed her to devote herself so thoroughly to the sick daughter. It is, however, highly probable that the brain-damaged child's need for her physical care was taken as an excuse for covering up her lack of finer and deeper motherly feelings, which may already have been at the root of the puerperal psychosis.

A connection between the early neglect due to the mother's psychosis and the encephalitis about 10 months later is hardly probable, unless, as a result of deficient maternal care, we assume a generally lowered resistance or a lack of proper attention during the febrile illness itself or, on the other hand, a hereditary weakness of the central nervous system.

(16) *Parental Attitudes*.—If we turn to Graphs VII and VII a, presenting parental attitudes, we note, for the postencephalitic group, a distribution fairly similar to that in the oligophrenic group, but with the weight a bit more on the side of excessive concern than on lack of concern. Again we find the column for "acceptance" dwindle down to almost nothing, while the percentage of "rejection" rises significantly, when the group of combinations with neurotic manifestations is considered separately.

There is no need for presenting further examples, as a whole selection has already been given in the cases quoted above.

(17) *Physical Defects* (Table XVI).—80 per cent of the children were noted to have neurological signs that pointed to localized damage of motor areas and pathways, while only 11.4 per cent presented dysplastic signs, altogether 86.0 per cent of children with physical defects. If we compare these figures with these for the oli-

gophrenic group, where the rate for neurological symptoms of brain-damage is 57.8 per cent, the rate for malformations, however, 73.4 per cent, one may realize that the two categories differ sufficiently to allow their separate grouping.

As already mentioned, the absence of physical signs of organic brain-damage in 20 per cent of the children need cast no doubt on the diagnosis of a postencephalitic state, as, in children, behaviour difficulties, general restlessness and lack of concentration are known to be the typical consequences of encephalitis, while motor disturbances of the extrapyramidal type, though often associated with changes in character and emotional control, are characteristic for the adult postencephalitic patient.

It is, however, quite possible that this rate of 20 per cent children without permanent physical signs of the brain infection may not be valid generally. Children who suffer predominantly from physical handicaps, are more likely to be examined and treated in general hospitals, children's wards and orthopaedic and physiotherapeutic services. The cases brought to us possibly form a selection of those in whom mental defects and behaviour difficulties were more of a problem than the physical handicaps.

(18) *Former illnesses*.—While Table XVII only indicates all illnesses that had been registered during the child's life-time, and while there the figure for "encephalitis" is a very approximate one, representing merely an estimate, we shall now give a small table (Table 8) in which we have sorted out the infectious illnesses that produced the first symptoms of brain-damage (such as unconsciousness, convulsions, paralysis) and, in another column, other infections that occurred either before or after this decisive infection.

TABLE 8.
Former Illnesses of Postencephalitic Children

	Infectious Ill- ness provoking the Encephali- tic Symptoms	Other illnesses (Before or after)	Total
Typhoid	6	4	10
Small-Pox	4	—	4
Encephalitis or Meningitis as separate morbid entity	5	—	5
Cholera	1	—	1
Pneumonia	4	2	6
Other fevers	11	8	19
Small-Pox vaccination	3		3
Anti-Rabies injection	1		1
Total	35		

In this table, we have only listed as "encephalitis" those febrile states which had, at the time of their occurring, been diagnosed as such by a doctor. All states that had not been labelled explicitly and which we only supposed to have been of encephalitic type by inference, are listed under "other fevers" or then under the name of the infectious illness with which they were associated. The heading of "other fevers" may thus actually cover some cases of genuine virus-encephalitis, but also such infections as measles, whooping-cough and other unspecified ones which led to intracranial complications.

Table XVII indicates that 2 children outside the postencephalitic group had also suffered from encephalitis. The one child in the oligophrenic group, known to have had encephalitis, was counted as a combination of that group. One boy, classified as "neurotic", is known to have passed through a fairly severe attack of virus encephalitis at the age of 5. He did, however, not present the typical behaviour disturbances, but only a certain playfulness and disinclination to study. As he was the son of a neurotic father whom we knew very well as a regular psychotherapy patient, and who created a family atmosphere very conducive to emotional distortions amongst the children, we regarded any possible postencephalitic features as negligible beside the psychogenic factors.

One will see, when we come to the discussion of the functional groups, that quite a number of the children presented slight neurological symptoms, which however, were seldom known to children or parents, and that some of them had gone through severe physical illnesses which left them weakened and regressed for some time. It is therefore possible that our functional group may contain some children who would deserve to be called "postencephalitic". Again, one has to draw the dividing line somewhere in the gradual transition from affections with an essentially organic aetiology to those for which emotional factors are predominantly responsible. And for this, no point is probably any less arbitrary than any other. The main thing is to define clearly, where and why one has drawn the line and to remain aware of the imperfections of any such division.

From Table XVII, we can further see that the number of children who had suffered from infantile liver trouble, with 14.3 per cent, is considerably higher than in the oligophrenic group, where it only amounted to 6.2 per cent. The rate is similar to that amongst neurotic children, where the figures is 12.9 per cent. We hesitate to offer any explanation, as one would have to compare these rates with properly weighed figures for incidence in a general population of children, which are not available. It may, however, be of interest to add two observations: The brother of one girl, who himself was treated for a mild form of pituitary-diencephalic syndrome, suffered from infantile liver-cirrhosis in his childhood; equally the boy whom we have just mentioned, who, in spite of his having gone through encephalitis at the age of 5, we classified as neurotic, had been treated for "infantile liver" at the age of 1½ years. One knows that certain pathological processes, degenerative and perhaps also allergic, can selectively damage both, liver and certain regions of the brain-stem! It might be of interest to examine, whether children

who have suffered from infantile liver-cirrhosis are more likely to develop any cerebral complications in later febrile states or whether, in any other way, *e.g.* by developing neurotic symptoms, they betray a weakening of diencephalic controls.

(19) *Education*.—The fact that intellectual deficiency was not always the main symptom in postencephalitic children, also perhaps, in some cases, the onset of the disease at a time when certain abilities were already developed, are reflected in the table on educational standards (Table 9). Of the 35 children, 11 *i.e.* slightly less than 1/3, had attained some success in school, 6 of them even according to the normal standard for their ages. One boy, Ranjit (48), whose handicap, starting at the age of 8, was of predominantly motor type, had even fought his way through to 9th class by the time he was 14.

TABLE 9

Educational Standard of Postencephalitic Children

	Male	Female	Total
No education attempted	14	7	21
School failure	2	1	3
1st-4th class : according to age	2	—	2
below age	2	2	4
5th-8th class : according to age	3	—	3
below age	1	—	1
9th-10th class : according to age	1	—	1
Total	25	10	35

From the 21 children who had had no education, one will have to subtract at least the 9 who were examined at an age below 6 and whose intellectual abilities had not been put to the test yet by any attempts at schooling. We thus get 15 children of school-age unfit for education against the 11 who were able to profit by schooling.

One will again realize from this table, that a separation of this group from that of oligophrenia is justified from more than one point of view.

For many of the postencephalitic children, however, though their intelligence is not always directly affected, but perhaps rather impaired by lack of emotional control, the same special teaching methods as recommended for oligophrenic children should be available, if they are to profit at all from any schooling.

(20) *Problems of Adolescence*.—The age pyramid for the postencephalitic group shows no particular broadening out at the top, which might indicate that adolescence brings no particular problems for these handicapped children. In some cases, however, we find the same inability to control the newly rising energies. One adolescent of this group will be found amongst the children with delinquent features to be presented in a later chapter.

Fortunately, none of the parents who brought postencephalitic children of puberty age seemed to be intent on getting them married soon. All of the girls who were approaching marriageable age, were so severely handicapped, *e.g.* Jehan (35), that they were not even able to look after themselves and, as some of the oligophrenic girls, causing great embarrassment to the family by their shamelessness and lack of cleanliness during the menstrual periods. We can, however, not exclude that, in spite of all appearances, it may have been the hope of getting a girl even of this type married, that caused the parents to seek consultation at the age of 13-14, though the handicap may have been present since infancy.

In the postencephalitic adolescents aged beyond 16, whom we have counted amongst the adults, the inability to contain the rising energies of sex, aggression, self-assertion, anger, even in patients with little intellectual impairment, often seemed to be the main problem that led to neurotic or even psychotic distortions, in particular to paranoid elaborations.

(21) *Interests of Postencephalitic Children* (Table 10).—As in the previously discussed group, we only have information about the children's interests in about one third of cases.

TABLE 10.

Interest of Postencephalitic Children.

	Male	Female	Total
No interests indicated	16	8	24
Motor activity	4	—	4
Watching machines, vehicles	1	—	1
Fine clothes	2	—	2
Good food	3	—	3
Music	4	1	5
Noise	—	—	—
Playing with water	—	—	—
Manual Occupation	—	1	1
Cinema	1	—	1
Toys	1	—	1
Animals	1	—	1
Intellectual activity	1	1	2

Apart from the areas of interest already signalled for the oligophrenic children, *i.e.* motor activity, interest in machines and vehicles, food, clothes, music and also, each in one case only, cinema manual occupation, we find 2 children who liked to engage in intellectual activities, like reading, studying, playing chess. One little boy was intensely interested in animals, though not always in a friendly and constructive fashion, but at times engaging in rather cruel experiments.

Again it would seem that the interest in motor activity and music might open a way towards some kind of training and teaching. The general restlessness and inability to control motor impulses is often a main reason, why postencephalitic children cannot concentrate on any intellectual task. If, by rhythmical exercises, organized games, they can be taught to achieve some mastery and harmony over their motor functions, this can have a beneficial effect on the whole development.

(22) *Number of Visits and Possibilities of Treatment* (Graphs VIII and IX).—As for the group of oligophrenia, our chances of observing the children and of giving therapeutic advice, was limited to one consultation in the majority of cases. Only 31.4 per cent were brought for repeated visits, and half of these again only for 2 consultations. In view of this, even the meagre rate for improvements with 22.8 per cent, is quite remarkable, particularly if one also considers that none of the cases about which we got any news was considered as “not improved”. One can therefore assume that perhaps more of the children could have profited, if the parents had been more persistently cooperating in treatment, or perhaps even that, amongst the cases that did not return or report, there may have been some that benefitted by the prescribed drug treatment and our advice to the parents.

Some of the modern drugs do not only seem to have a beneficial effect on disturbed vegetative functions, such as excessive salivation, but also reduce muscular rigidity and facilitate control over motor impulses and emotions. Any small progress, however, can not only provide direct relief to the child, but may also stimulate hope and interest in the parents, whose changed attitude in its turn may have its effect on the child.

Whatever relief and progress may be gained by such drug therapy, an important point will be to utilize the available energies and capacities for some coordinated activity. If, as was reported in one case, the better motor control and power of concentration achieved by drug treatment in a 5 year old boy is only used by the parents to take him to long cinema shows,—probably so that neither of the parents may have to stay at home to look after him !—one doubts, whether anything has really been gained.

Only facilities for special schooling and, more perhaps than for mentally deficient children, also for physiotherapy and vocational training, can assure the best possible development for children handicapped by encephalitic processes. Along with this, proper guidance for the parents can help them to find the right encouraging attitude, which neither over-anxiously restricts nor over-ambitiously drives the child.

On the preventive side, which, contrary to the group of congenital mental deficiencies, offers some scope, more universal vaccination against small-pox and similar protection against other infectious diseases may bring down the rate of encephalitic complications. At the same time, however, vaccination practices may have to be applied with the necessary discrimination, *e.g.* exempting children who are suffering from or have just gone through an acute illness or who may possibly be in the incubation period of some infectious disease with which they have had contact. Parents of children

who have ever manifested convulsions or even only "jerks" in fever, should be warned to consult a doctor or to administer antipyretics, perhaps anticonvulsants and other sedatives until expert help can be reached, whenever the child develops any high fever, *e.g.* also after vaccination or other procedures of immunisation. Once a child has shown signs of involvement of the central nervous system during a febrile illness, sufficient rest and other appropriate care is to be granted during the period of convalescence. Any signs of paralysis in limbs have to be carefully watched, so that proper physiotherapy in the form of massage, passive and active exercises, possibly temporary splints, *e.g.* at night, may prevent atrophies and contractures. Though all these measures may, strictly speaking, not be the concern of the psychiatrist, we again have to think in terms of psychosomatic wholeness. Any physical handicap will have its deep repercussion on the emotional development of a child, but possibly also on the functioning of his intellectual capacities. Child guidance clinics should therefore not only have the cooperation of a medically trained psychiatrist, but also easy access for their patients to orthopaedic and physiotherapeutic services, while clinics and homes for crippled children, on the other hand, should have the cooperation of child psychiatrists and psychologists. Only if the problem is attacked from both sides, the physical and the psychological, we can hope to make the best of what abilities are left in a postencephalitic child.

4. Epilepsy.

(a) *Definition, Differential Diagnosis.*

As the dramatic happenings of a convulsive fit are so typical, epilepsy or "the falling sickness", has been recognized as a particular disease already in ancient medical systems of East and West. The sudden shriek, the fall, loss of consciousness, jerking of limbs, foaming mouth and then the sleeplike state in a person who appeared healthy a moment before, seems to have struck people as something so unexpected and inexplicable by any natural cause that, not only in ancient times, but amongst the less educated people even nowadays, the assumption of a supernatural origin, in particular possession by a ghost or a deity, certainly does not seem to be far-fetched. Such views were reinforced by the fact that the same people who have epileptic fits, at times also report religious visions or describe the "aura" immediately preceding the fits as being touched by some invisible "presence". The old Romans called epilepsy the "morbus sacer", *i.e.* the sacred illness, a term which occasionally is still used by Western doctors, usually as an euphemism, if in some report or discussion they do not want to scare the patient or his relatives by the more common name. In Hindi and Sanskrit, the term "apasmāra" (loss of memory, forgetting), probably refers to the loss of consciousness during the fit itself, but may possibly have some connection with the dementia that gradually overcomes patients who have frequent, unchecked fits. The other, more customary name "miragi" or "mrg.", according to Hindi dictionaries, is supposed to be derived from the Sanskrit root "mrg". It is, however, not quite obvious, how this root, which is connected mainly with certain forest animals and hunting, should serve

to derive a name for epilepsy, unless we assume that the epileptic in his fit is likened to an animal slain suddenly by the hunter's weapon. It would be much more plausible to trace it back to the root "mr.", "dead", which provides some derivations with the sense of "unconscious, corpse-like".

Modern medicine, armed with ingenious techniques for the microscopic study of brain-tissue, the chemical analysis of body-fluids and the registration of electric action currents, still recognizes the epileptic fit as a well-defined symptom or syndrome, but no longer as what one would call a "morbidity". On one hand, one establishes a distinction between fits that seem to proceed from an irritation of the cortical structures of the brain and those that seem to have their origin in the deeper centres of the brain-stem, where consciousness itself is supposed to be "localized"; on the other hand, one assumes that certain types of fit can be produced by mechanical action through injuries, scars, blood-clots, tumors, while others, without any local lesion or compression of tissue, are due to changes in the chemistry of body-fluids, and, finally, one admits that stimulation of sense-organs of a quite particular type or emotional tension can release a fit, again of course mediated through chemical and electrophysiological processes.

There is perhaps no other psychiatric phenomenon for which the importance of what we called a "sliding scale" of factors, starting from the purely physical organic and ending in the predominantly psychological, or starting with heredity and ending up with purely external causing agents, is as obvious as for epilepsy.

We thus find that, in modern medicine, the old concept of epilepsy as a definite unit of illness has, on one hand, disintegrated into a mere symptomatic phenomenon or "reaction type", which can have many different causes and meanings; on the other hand, epilepsy as a psychiatric category, embracing physical and psychological manifestations that seem to spring from a similar constitution, has been enriched by the inclusion of certain paroxysmal disturbances and even a basic mental and physical disposition, *i.e.* features which lack the typical characteristics of the convulsive fit. How then, apart from specialized electro-physiological investigation, are we to find the common link between all these varied phenomena?

The Sanskrit and Hindi term "apasmāra", though possibly it may only have referred to the senselessness in the actual fit, seems to come fairly close to an element which is common to all the phenomena included in the old and the newer concept. The central problem of the epileptic seems to be remembering, retaining (Sanskrit: *smr.*), either in its positive extreme of tenacious clinging and perseverating, or then in its negative aspect of forgetting, of destroying any trace of memory. The temperament of the typical epileptic is described as slow, viscous, perseverating, clinging in repetitious monotony to a few stereotype ideas, while the fit with its brutal wiping out of all memory traces and, in chronic cases, the increasing dementia with its gradually obliterating effect on memory, present the anticlimax. Perhaps even the customary slow waves and the sudden irruption of fast and irregular rhythms in the typical electro-encephalogramme of the epileptic illustrate this basic contrast. The tendency to moralize and to perceive everything in terms of fixed aesthetic and ethical values, the often

fanatic sense of justice and the persistence in grudging resentfulness over any trifling injury, indicate perhaps that the tendency to retain and fix is not a total one, but only concerns that which can be reconciled with a certain ideal image the epileptic has of himself. Whatever does not fit in with this "good aspect" of himself, has to be abolished, forgotten, wiped out or, at least, will only find a place in action, when consciousness is dimmed or when the person is so-to-speak "beside himself" or "beyond himself" with anger or some other passion. It would then seem that the tenacious clinging, far from indicating a particularly powerful ability to retain, would, on the contrary, betray a basic lack of capacity for containing and retaining. A lack of quantity may appear to be compensated by increased "quality". This quality, however, has no flexible, living element, but is determined by a rigid "all-or-nothing" response.

May one then, perhaps, subordinate the phenomena of epilepsy again to the central problem which we tried to formulate for oligophrenia? An inability to receive the "outside" world into oneself, to digest and assimilate whatever is offered, in a fashion that guarantees the flexibility, variability and capacity for growth and transformation typical for any living organism? And if this is so, may we again assume that, in certain cases, the ones which one would call "symptomatic epilepsy", the conditions for actualisation of this life-force, its physical channels, are insufficiently developed, damaged or destroyed, while in others, which would deserve the term "genuine", the life-force itself might have been poorly apportioned to a particular creature? Again, we cannot answer these deeper questions, but only stimulate thought into going beyond the mere isolated phenomena and their superficial explanation through findings of the basic sciences.

Coming back to more concrete facts, we have to delimit the group which has been termed as "epileptic" in our material. We have already repeatedly explained that those cases in which convulsive fits only occurred sporadically, in early infancy or during febrile states and other exceptional situations, have not been included in our group of epilepsy, even in its wider form. Such cases are simply indicated as having presented convulsive phenomena, in the table on "reasons for consultation and main symptoms" (Table IV). Within the group of epilepsies in a wider sense, we have included those cases in which convulsive fits of some regularity formed part of the manifestations of a dysplastic or damaged brain, without, however, being the first and main evidence of such cerebral insufficiency; in other words, what one might term as "symptomatic epilepsy".

We have already described cases of oligophrenia and postencephalitic states which were associated with the epileptic syndrome; they have been listed as "combinations with epilepsy" of these respective categories.

As oligophrenia and infectious processes in the brain, however, are not the only conditions that can lead to symptomatic epileptic manifestations, the group that remains to be discussed now, under the heading of epilepsy, still contains a few cases in which

the fits have to be considered as "symptomatic", namely those in which an accidental brain injury may have been the provoking cause. Other causes, such as intoxication, tumor, degenerative processes or vascular incidents, do not figure in our group of children.

Amongst the remaining cases, which might deserve the designation "genuine", we can distinguish patients in whom the fits, probably on a hereditary basis, occurred since infancy, *i.e.* from a time at which a psychogenic release is improbable, while others are marked by a start of the fits at or shortly before puberty age, when the contribution of emotional factors to the formation of epileptic phenomena is highly probable. During recent years, the possibility that typical epileptic fits can be psychosomatic manifestations of emotional tension, has been more and more accepted, and cases have been reported in which, by prolonged psychotherapy alone, without any physical treatment, a patient could become free from fits.

While, thus, one might be at a loss where to draw the line between epilepsy as a syndrome with doubtlessly gross physical involvement and the functional group of diseases (a question which would be valid for most psychosomatic diseases in which anatomical lesions can be demonstrated !), there are certain other differential diagnostic distinctions, which can be made more definitely and neatly : the distinction between the epileptic fit correlated with a faulty brain activity, which can be electrophysiologically registered, and, on the other hand, tetanic, vegetative and psychogenic fits.

If a patient or his relatives report "fits", the first thing is to get an exact description of the paroxysmal happenings. As already mentioned, the typical epileptic fit starts usually with a shriek and fall. Then a short phase of cramped up stiffness of the body is followed by often violent rhythmical jerks of the limbs. Saliva is beaten into froth and, if the tongue happens to be bitten by the often firmly locked jaws, this froth may be tinged with blood. Often the patient voids urine or even stool during the fit. After the convulsive phase, the patient may continue to be in a state of unconsciousness or somnolence for any length of time from minutes to hours. Breathing often is heavy and stertorous, while during the first part of the fit it may be arrested. On regaining consciousness, the epileptic is usually confused and lacks all recollection for the happenings during the fit and possibly shortly before it. In some patients, the fit is announced by some unusual sensation, while others fall down without any warning. This forewarning, called "aura", may consist in the perception of some light, some sound, some light touch on the skin or a tingling inside some part of the body or even in some experience that cannot be definitely limited to any one sensory stimulation, as *e.g.* an indefinite impression of some strange "presence". One of the children we examined, in whom the fits seemed to be of encephalitic origin, described this premonitory phase as a vague sensation, "more inside than outside", that some monkeys were trying to scare him.

Some fits, which are still counted as epileptic, may not quite follow this typical sequence. The clonic phase with its rhythmical movements may be negligible or com-

pletely lacking, so that unconsciousness and stiffness of the body are the main features. In what is called "petit mal" or "absence", a lapse of consciousness of a very short duration, motor phenomena may play no role at all or consist in such minor manifestations as an increased blinking of the eyelids, some stereotype movement of the fingers or a loss of tonus of a limb, which may for instance lead to the dropping of an article held in the patient's hand. If the patient is engaged in talking, while the fit occurs, the observer may note a sudden break in the flow of speech and, after a few seconds of silence or possibly automatic repetition of some syllable, slight confusion and lack of memory for the point at which the conversation was broken off. Some patients even retain a certain degree of consciousness during such minor fits, but lose control over some particular mental function. One of our adult patients, who at times also had major fits, reported that he would suddenly realize at such moments, that he was continuing automatically to speak, read or listen to someone's talking, but without being able to penetrate to the meaning of the words spoken, read or heard, which appeared like those of some unknown foreign language. He even was so much aware of these happenings, that he had developed some clever techniques for covering them up, as for instance going to the blackboard and drawing a sketch, when overcome by the fit while lecturing. Other patients again will merely be vexed by a persistent or repetitive compulsive thought which holds them in its grip for a few seconds or minutes.

All these phenomena, as also some longer lasting states of reduced or altered consciousness, called "twilight states" or "psychomotor equivalents", can be safely classified as epileptic, if the same patient also has major fits, or if the electro-encephalogramme (registration of the electrical activity of the brain cells), shows deviations typical for epilepsy. Until electro-encephalography provided a method for diagnosing epileptic phenomena with a very high degree of probability, exact description or observation of a fit, together with an impression of the patient's personality and perhaps information about heredity, were the only means one had for distinguishing true epileptic phenomena from some fits of a different nature.

The ordinary "fainting fit", due to a momentary lack of blood-supply to the brain, is usually characterized by slackness of the limbs, paleness (in contrast to the often congested, bluish colour of the epileptic), weak pulse and lack of any frothing from the mouth. Distinction may be less easy, if a fit is of so-called "tetanic" nature (not to be confused with the infectious illness "tetanus", in which similar phenomena also occur, but with a quite different aetiology and a very unfavourable prognosis !). Either lack of calcium and vitamin D or of certain other substances in the blood or a change in the usual proportion between oxygen and carbon-dioxyde, *e.g.* through forced breathing, can provoke a fit of stiffness of the whole body with a very particular cramped up position of hands and feet and characteristic distortion of the face, which may closely resemble the tonic stage of an epileptic seizure. Usually, however, the patients retain consciousness. Diagnosis may be possible with the help of blood-analysis and of certain signs of muscular and nervous hyper-excitability, which are present even outside the acute fit. In some patients, however, tetanic elements may be mixed with epileptic features or, on the other hand, form part of hysterical manifestations.

Hysterical fits, *i.e.* a partial loss of consciousness, possibly a fall, accompanied by dramatic postures or movements of the body, often also by some emotionally charged exclamations, may not only resemble tetanic attacks, but also certain phases of epileptic seizures. One may even find that, in one and the same patient, epileptic manifestations can be utilized in the service of some hysterical tendencies, while at other moments they seem to occur without any particular "psychological" need. Differentiation can thus be quite problematic. The loss of consciousness in hysterical fits is not as deep as in epileptic seizures, but, as hysterical phenomena usually aim at concealing some particular thoughts and emotions,—though at the same time also at revealing !—any traces of a possibly present awareness during the fit may be suppressed even after it. Some authors maintain that, under hypnosis, a hysterical patient will be able to remember what has happened during the fit of "unconsciousness", while the epileptic, whose ability to register any sense impression is completely blotted out during the seizures, will not even recall anything in that condition.

Apart from electro-encephalographic registration, for which the opportunities here in India are still rare, certain techniques of provocation (injection of Cardiazol, forced hyperventilation, stroboscopic stimulation by light signals of a particular frequency) may help to produce epileptic or tetanic fits in a person with the particular disposition. Apart from these methods, only exact observation and assessment of the patient's whole personality can determine the nature of doubtful fits.

Amongst the children examined, there are several who had been brought because of "fits" of non-epileptic nature. They are classified in the group of neurosis. Some others described, usually on a special inquiry, moments of confusion or blankmindedness which made one suspect "petit mal" fits, but which may just as well have been signs of a functional inability to concentrate and to ward off the intrusion of idle or preoccupying thoughts or the paralysing effect of some hidden anxiety. Again, however, one will realize, how closely many of the described phenomena may be connected with each other, how, on one hand, a strong emotional tension may take hold of even a slightest disposition to any paroxysmal discharge, while, on the other hand, a defective central nervous system may respond with a "brain-storm" to an almost imperceptible stimulus.

(b) Causes and origin.

The various causes that can concur to produce epileptic manifestations, have already been discussed in the preceding paragraph. We sum up shortly that, on one hand, a certain hereditary constitution seems to favour particular character features and a tendency to paroxysmal discharge of tension, while, on the other hand, any injury to the brain, according to its localisation, can provoke either a "focal" spasm of certain parts of the body or, with various stages of transition, a generalized convulsive fit. Furthermore, we have seen that, when the disposition favours the occurrence of fits, they can be released by chemical changes in the body-fluids (*e.g.* lack of blood-sugar, shifts in the pH changes in CO₂ tension), through certain sensory stimuli (flicker effect, pressure on so-called "trigger areas") or even through emotional factors.

In each particular case, all these possible factors have to be weighed against each other. Assessment of their relative importance may provide a basis not only for prognosis, but also for suitable treatment by drugs and advice for healthy living.

(c) *Combinations.*

The possibilities of combination realized in our material have found mention already in the paragraph on definition and differential diagnosis. In tabular form, we can present them as follows. (Table 11).

TABLE 11.

Combination of Epileptic Manifestations with other Psychiatric Disorders.

	Oligophr.	Post- enceph.	Epilepsy	Org.	Neurosis	Total
All cases in which convulsions occurred at any time of life (incl. fits in fever and infancy)	23	25	13	1	8	70
Epileptic manifestations occurring regularly, as combination of other congenital-organic groups	12	2				14
Epilepsy as primary trouble (pure and with neurotic overlay)			13		6	19

The table indicates that, of the 70 cases which were known to have manifested convulsive fits at any time of life, only 33, *i.e.* less than half, suffered from such fits with sufficient regularity to justify the diagnosis of an epileptic disorder, while, in the remaining 36 cases, the sporadic fits occurred mainly in early infancy and during high fever.

In the neurotic group, though quite a number of children had had brain injuries or states of unconsciousness and delirium in high fever, only 2 were known to have had convulsions. The remaining 6 cases contained in the figure of 8 cases, are those in which epilepsy was complicated by neurotic features or entirely a psychosomatic expression of emotional conflicts, and which are again mentioned in the column lower down. The fact that no convulsions had been signalled in any of the children of the 2 psychotic groups, and that none of the patients in these groups (see Table VII) has any epileptic relatives, seems to confirm certain theories, according to which there is an antagonism in the constitutions that favour epilepsy and schizophrenia respectively, so that the two diseases are seldom found in the same patient or even the same family. The case-

histories of our adult patients are less likely to serve as proof for this view ; amongst the children, however, though in their "choice of symptoms" they seem to have the freedom of even greater plasticity than the Indian adults, it seems to hold good.

Amongst the neurotic children, we noted one case of an adolescent, presenting signs of slight brain-damage, who may, amongst many other neurotic and almost psychotic symptoms, have had some "petit mal" fits. Some of the girls had fits of hysterical or tetanic nature, in which an epileptic component could not be quite excluded.

The second column contains the cases in which we regarded epilepsy as a secondary manifestation of a basic brain deficiency which, in first line, had produced oligophrenia or postencephalitic behaviour disorders. These 14 cases, and the 19 contained in the next column, were counted as epileptic manifestations in a stricter sense.

To epilepsy as the primary trouble, we have given the third column. This contains 13 cases in which no complications were noted, while in 6 cases, the epileptic disorder was combined with a neurotic overlay or entirely in the service of psychosomatic symptom formation. One will see that, after elimination of 2 cases of traumatic epilepsy, only 11 cases were regarded as deserving the name "genuine". Even amongst these, there were some in which the convulsions may have been merely the symptom of some brain-defect which, however, had not produced any distinguishable other disturbances.

Again, particularly in view of the fact that in many cases we had no chance for thorough investigation, this classification is somewhat arbitrary. It attempts to bring some order into a diagnostic group for which, as we have seen, many different causes and combinations of causes can be responsible.

The following paragraphs will only deal with the 19 cases in which epilepsy was considered as the primary and main disorder ; the combinations with oligophrenia and postencephalitic states have already found their place in the previous chapters.

(d) Special Characteristics of our Material.

(1) *Distribution according to sex.*—With a ratio of 2·1 : 1, the proportion between boys and girls approaches that in the total material and, compared with the groups of oligophrenia and postencephalitic states, shows a less marked predominance of boys. If we take into account all the children of the congenital-organic group who had had convulsions at any time, we get a similar ratio of 2·3 boys to 1 girl. Again we cannot know, whether this reflects a true incidence or whether boys have been considered as more worthy of investing money, time and concern in consultation.

(2) *Distribution according to Age* (Graph I b).—The slender age pyramid, contrary to the postencephalitic and similar to the oligophrenic group, shows a slight broadening out at the top. This accumulation of cases in the age group from 11—16 and in particular at the ages between 14 and 16, does not have quite the same significance as amongst oligophrenics. Of the 9 boys aged above 11 years, 6, and of the 3 girls of

that age-group 2, *i.e.* in both cases 66·6 per cent, had only started their fits shortly before consultation, while amongst the mentally deficient children, those who were only brought at puberty age, had presented defects since earliest infancy. The time of consultation, in this group, corresponds more closely to the onset or exacerbation of symptoms than in the group of oligophrenia.

We have sorted out into 3 sub-groups the children who started fits at an early age, before 5, those whose first fits occurred after the age of 5 (including start during puberty age) and a few in whom sporadic fits in infancy, followed by a "free interval", only reappeared at a later age. (See Table 12)

TABLE 12.

Onset of Symptoms in Epileptic Children

	Pure Cases			Cases with Neurotic Overlay			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Total cases in group	8	5	13	5	1	6	13	6	19
Fits since infancy (earlier than 5 years)	4	3	7	2	—	2	6	3	9
Fits started after age of 5 years	3	2	5	2	1	3	5	3	8
First few fits in infancy ; later manifesta- tions after long free interval.	1	—	1	1	—	1	2	—	2

An example of each group may illustrate this division :

- (50) *Ram*, a Brahmin boy of 10, was brought by his parents on recommendation by one of our former patients. After a normal delivery, he had started having convulsive fits at the age of 4 months, without any particular provocation. First they only took place after intervals of several months, but from the age of 3 their frequency increased. The parents described them as starting with headaches and manifesting the typical sequence of tonic and clonic phase. The child presented some dysplastic signs: strange shaped head and prognathic teeth, but no symptoms of organic brain-damage. By the time we saw him, and in view of the early start of the fits, it was difficult to say, whether his mental defect may possibly have been present right from birth, even before the onset of fits, or whether it was due to epileptic dementia.

An example for late onset of fits :

- (51) *Maya*, was a Christian girl of 14. Her father, a railway workman, became mentally ill during the first year after marriage, before the girl was even born. He had since been living with his parents in a state of chronic psychosis.

Maya remained with her mother, who took up training and work as a midwife, and with her maternal grandparents. During infancy and early childhood, she developed normally, but was always rather quiet and shy. At the age of 5, she had typhoid with high fever. She recovered without any signs of permanent impairment. In school, she was an average pupil and had reached 6th class of an English institution at the age of 14.

It was only at the age of 13, about one year before menarche, that the epileptic fits started. The mother described them as follows : the child would get irritable, so that she could hardly bear anyone talking to her. Then she would complain about darkness before the eyes, suddenly turn head and eyes towards the right and fall down. After the convulsive stage, she would remain unconscious for 1-2 hours. Since she had started having the fits, she had become forgetful, irritable and at times depressed. She had more difficulty in following in school, but, stimulated by the mother's pride and her own ambition, she forced herself to study until late at night. It was often during these moments of excessive intellectual exertion that the fits occurred.

The girl was delicate and well proportioned, except for the somewhat bulging forehead. We noted some asymmetry of mimic movements, excessive fluttering of eyelids, wide pupils, at times twitching of the facial muscles. Her hands were damp and cold. On the left leg, we elicited some abnormal reflex responses.

In this case, the start of the fits with a "déviation conjuguée" (spastic turning of head and eyes towards the same side) and the neurological signs point to a focal form of epilepsy. Unless we assume some damage to the brain through the attack of typhoid at the age of 5, no particular cause is known. As to the type of mental illness her father suffered from, we have no details.

Some tests for memory and concentration betrayed that the girl's intellectual capacities had already considerably deteriorated. In any task that required intensive concentration, she would make mistakes without being aware of them and even "lose her thread" completely. We also noted in her some of the features described earlier as typical for the epileptoid character : neatness and tidiness in all her habits, a great sense of moral propriety and justice, excessive and persisting concern about any act of injustice or cruelty she witnessed. Along with this, she displayed a tenacious persistence in anything she was doing. The occasions on which her anger was most likely to burst out, were when someone asked her to do some little errand, while she was engaged in some other pursuit.

With suitable medication, we were able to reduce the fits almost completely. The mother cooperated very well, bringing the child for 7 consultations, once even late at night, immediately after a fit ! The only thing we could not make her understand was that, for this delicate and brain-damaged child, who probably had never been very gifted intellectually, persistence in ambitions for higher studies may have been too much of a strain.

Isolated fits in infancy and a more regular reappearance at pre-puberty age were noted in the following case :

- (52) *Ismail*, 7th of 9 children of a Muslim businessman, was examined at the age of 12, about 6 months after the onset of fits which seemed to be of epileptic nature.

Born after 6 sisters, two of whom had died in infancy, Ismail was the first boy in the family. For 5 years he remained the youngest and only son and was correspondingly pampered by everyone, including breastfeeding up to the age of $2\frac{1}{2}$ years. Later, two more boys were born. We know that one paternal aunt suffered from mental trouble, probably a severe compulsive neurosis. The boy's mother, the father's second wife, at times had hysterical fits of crying. The father complained of some stomach and skin trouble, probably of psychosomatic origin.

After an uneventful pregnancy and delivery, Ismail developed normally, walking at 14 months and talking a little later. At the age of $1\frac{1}{2}$ years, he had a few convulsive fits. After treatment for intestinal parasites, the convulsions did not recur up to the age of $11\frac{1}{2}$, when a first fit took place under the stress of an examination in school.

The description of the fits by the boy himself and by the family left some doubt as to their true epileptic nature. He mentioned some kind of vague premonitory sensation, then a state of "unconsciousness", in which he could neither speak nor see nor move, but was able to hear faintly what was going on round him. The fact that the fits mostly occurred at moments, when he was scolded or in some other way frustrated, make it very probably that a considerable emotional component was involved. In view of the typical convulsive fits observed in infancy, however, one has to consider the possibility that the puberty-crisis, through which this pampered, undisciplined boy was passing, made use of a latent readiness for epileptic manifestations and that gradually, more typical fits might have developed. The boy certainly seemed to derive quite a bit of advantage from his symptoms, as the overanxious parents and other family members now tried to spare him any occasion for irritation and anger. He had even been allowed to stay away from school. The boy, who had been brought from a city at some distance, did not return after the first consultation.

(3) *Reasons for Consultation and Main Symptoms* (Table IV).—The main reason for consultation, of course, were the fits. In one of the cases of this group, however, and in some others with convulsions classified in previous groups, the parents first tried to conceal the fits, only signalling the mental retardation and behaviour disturbances. In at least one of these cases, it seemed that the parents wanted to test the doctor's capacities by letting him find out the essential feature himself. In other cases, also amongst the adults, people of low educational standard may either have considered the fits, which they regarded as a sign of possession, as a matter not to be put before a doctor, or they were afraid of annoying the possessing ghost by mentioning what they considered as the manifestation of his presence.

According to Table IV, behaviour changes, mostly consisting in irritability, stubbornness, fits of anger, were signalled in 17 of the 19 cases. The figure of 12 cases with intellectual defects sums up, not only those patients in whom severe mental deterioration was a consequence of a long series of fits, possibly over many years, but also the ones in which a more recent onset of fits was accompanied by a marked lack of concentration. A motor handicap was only present in one case with early onset. Outright delinquent features were not observed in any of the epileptic children; 3 cases, however, have been counted as "potentially delinquent."

This may also be the place to mention those cases, in which the epileptic manifestations did not quite conform to the typical pattern of the convulsive fit.

Focal seizures, starting in a well defined region of the body and not always ending in generalized convulsions, were reported in 4 children. A typical case is that of :

- (53) *Suman*, a 15 year old girl. She was the second born and eldest daughter amongst 5 children of a Hindu engineer. She was born by breech delivery, but without any extraordinary complications. She learned to walk and talk at the age of one year and, when sent to school at the age of 6, found no difficulty in learning. No severe illness or accidents disturbed her physical development. At the age of 5-6, however, she noted that, when washing in cold water, her right hand and arm started to jerk and tremble. At the age of $13\frac{1}{2}$ years, at about the time when she had the first menstruation, she started having fits. The first thing she would note, was a tingling in her right hand, a general uneasiness and nausea. If, at that point, someone could take a tight hold of her right arm, the fit could be cut short. Otherwise, the right arm would start jerking, the face would turn to the left and at times generalized convulsions would follow.

The intelligent girl who, at the age of 15, had reached 10th class, was worrying, depressed and anxious about these uncanny seizures that took hold of her more and more frequently. The parents seemed to have an attitude of expecting rather too much of this eldest daughter. Her responses to some test situations revealed feelings of insufficiency and guilt, probably about not coming up to her parents' expectations and her own high moral standards. On neurological examina-

tion, we noted an asymmetry of facial innervation, a lack of coordination in the movements of the right hand and foot. Again, unless the abnormal presentation on delivery is regarded as a possible origin, we do not know, what might have caused localized brain-damage.

Minor fits, "petit mal", and what one calls "psychomotor equivalents", without any major fits, were found in one case :

- (54) *Balram*, aged 14, was brought by his relatives, because, during the last 6 months, he had several times run away from home in a state of disturbed consciousness. At the same time, he had become absent-minded, quiet and depressed. He himself gave the following account :

He first would feel some tingling sensation in his feet. Then a dreamlike state would come over him and he could not remember afterwards, what happened during it. He knew that he must be walking and roaming about, as several times when he came to his senses, he found himself in unknown surroundings and had to ask his way back. He also found that, occasionally, in this state, he had done things which normally he would not think of, *e.g.* asking some boys for money and walking away with it. Already before these prolonged states of altered consciousness occurred, he noted that, at times, he lost the thread in conversation. At other times, he felt suddenly overpowered by violent anger, ready to kill someone. He could not think of any plausible reason for his running away and, in his normal state, was very much ashamed of these escapades. As for the last few months he had experienced some difficulty in concentrating on mental work, he had left off going to college, where he had been studying in first year Intermediate.

On physical examination, we found a slight deformation of the spine, corresponding to the back-ache about which he complained. No pathological reflexes were found ; but stimulation of the footsoles produced an unpleasant sensation, similar to that which usually preceded the fits of running away.

The boy's previous history renders it probable that, in this case too, some emotional tension may have made use of a weakness of [some brain region in forming a symptom : *Balram* was the youngest of 3 brothers. His mother died, when he was aged 1½ years. Up to the age of 9, he remained in the village with his father, then moved to Lucknow to get some higher education, while living with his elder brothers. He was always one of the best pupils in his class, took interest in football and cricket and enjoyed inventing stories. 8 months before we examined the boy, his father had died. Since then, he had been depressed and absent-minded and, about two months after this event, the fits started.

The boy's responses to some projective tests made one guess that he felt some insecurity, perhaps also some resentment about having to obey his elder brothers. At the same time, one got the impression that the boy had set very high moral

ideals for himself. In his dreams, however, and possibly also during the states of altered consciousness, the suppressed tendencies found an outlet in scenes of aggression.

Though no actual delinquent act had been signalled, we regarded this boy as "potentially delinquent". He is therefore included in the small group of children with delinquent features which is to be discussed separately later.

In another boy of puberty-age, psychomotor equivalents, possibly on the basis of some traumatic brain-damage, were the only epileptic manifestations :

- (55) *Hilal*, a Muslim boy of 14, brought from a city outside U.P., was the eldest of 4 children of a railway official. One of his sisters was born with a cleft palate. No psychiatric illness was known of in the family.

After a somewhat difficult delivery, when the mother was aged 19, the boy developed normally, being breastfed up to the age of 10 months. He started school at the age of 4. Though he usually was one of the youngest boys in his class, he always held a good position. At the age of 7, he fell from a height of 8 feet and was unconscious for several hours. No untoward consequences were noted at that time.

His position as the eldest son in the family seems to have been somewhat vexing : Everyone expected him to be reasonable and to set a good example to the younger siblings and to give in in any quarrel. He reacted to these demands with a certain stubbornness and irritability. Though he was much more obedient and accepting outside the family, being sent to a boarding school at the age of 13 also did not suit him and, at the time when we examined him, he was living at home again and visiting 8th class of a day-school.

Since the age of 12, *i.e.* 2 years before he came for consultation, he had had "fits" preceded by headaches. According to the family, he would lose consciousness, then go into automatic talking, moving his head in a strange fashion, crying, biting and tearing clothes. The fits were most likely to occur, when he was angry or when someone scolded him. He himself could not tell what happened during the fits, but only knew that, just before losing consciousness, he experienced some kind of an "electric current" in the lower part of his back and that, on regaining his senses, he felt some pain in the body and had to pass a lot of urine. In between fits, he often suffered from headaches and he had noted that his memory had deteriorated.

On physical examination, we found, in the small and delicately built boy, a certain asymmetry of the skull, the left occipital region protruding more. The muscles of the left shoulder and arm were slightly atrophic, and the left hand looked more delicate than the right. Strength and coordination of movements were also

reduced in the limbs of the left side and, from the left footsole, a pathological reflex was obtainable. In addition, the skin on the whole left side of the body was more sensitive to light touch, with a limit that did not suggest a hysterical disturbance. These neurological findings, together with a small scar on the right forehead, rendered it highly probable that the accident at the age of 7 may have had some connection with the fits. The result of the Rorschach test confirmed the epileptic nature of the fits. Again, however, we have to consider the possibility that any brain damage sustained at the time of the fall, might not have led to epileptic manifestations, unless emotional tension at the age of puberty had made use of it for its symptom formation.

(4) *Local Origin* (Table III). The small percentage of epileptic children coming from villages, only 5.2 per cent, has already been pointed out earlier. It can hardly indicate any real difference in incidence between towns and rural surroundings. We suspect far more that, in villages, and also amongst the less educated classes in cities, epilepsy is still regarded as due to possession by evil spirits and that, therefore, religious ceremonies and various practices for exorcism, such as branding with hot irons, amulets, incantations and fumigations, are regarded as more promising remedies than what modern medicine may have to offer.

Again it is perhaps significant that the only boy brought from a village, already at the age of 2, was the only surviving one of 4 children of a Shudra family.

The fact that more children were brought from outside Lucknow than from the city itself, may have at least 2 plausible explanations : It may be that, in a town with a Medical College and many well-known practitioners, cases of epilepsy find suitable treatment even outside a psychiatric clinic. On the other hand, the relatively high percentage from cities outside U.P. (15.8 per cent), amongst them Bombay and Delhi, may indicate that, in the hope for a definite cure, parents are not satisfied with the instructions for continued medication which doctors or even specialists give them, but still hunt further afield for the great miracle-worker who will end the trouble with one magic stroke.

Migration had only played a role in the form of frequent transfers of the father in one case, and in moving from the village to his relatives in the city in the case of Balram (54) already quoted.

(5) *Community and Caste* (Graphs II and III).—The only salient feature in distribution according to communities is a fairly high percentage of Christians. It would be hardly worth mentioning, considering the small number of cases in the group, if it did not coincide with a similar relatively high figure of Christians amongst the adult epileptics. Certain features one finds in the so-called "epileptoid character", the strict moral values, the excessive sense of justice, the somewhat fanatic and exalted piety, may perhaps dispose in a particular way towards accepting conversion to a new religion, while, on the other hand, the ambition of proving a worthy member of the new religious

community may play a role, at least in first generation Christians ; but one also has to consider that Christians, who usually have some contact with mission hospitals and dispensaries, may be more enlightened about the nature of epilepsy and resort to medical methods rather than to exorcism.

In the graph (Graph III) which illustrates the distribution of the Hindu castes amongst the epileptic children, one is surprised to find no Kshatrya at all and, particularly in contrast to the two previously discussed groups, only one Brahmin, amounting to 7.5 per cent of the Hindus. Unless one assumes that these 2 castes are the ones that have easiest access to good private practitioners and also the persistence to follow their advice, one may have to consider the possibility that some constitutional factors may dispose one caste to epileptic manifestations less than another. One will note from Graph III that the share of scheduled castes in the group is quite considerable.

(6) *Occupation of Father or Guardian.* (Graph IV).—The class most frequently represented amongst the parents of epileptic children is that of the junior position in service. In contrast to the groups of oligophrenia and postencephalitic states, academic professions and high positions in service, as well as business families, only form a small share. The complete absence of any children from farms seems to point in the same direction as the small figure for children brought from villages.

(7) *Joint and Individual Family* (Graph V).—15.4 per cent of the epileptic children came from joint families. In contrast to the 2 previously discussed groups, the percentage amongst the cases with functional complications is not higher than amongst the "pure" cases, but, on the contrary, amounts to 0. We must, however, repeat that information about the status of the families was not complete. In view of the smallness of the group, the figures actually collected may therefore hardly have any significance.

(8) *Lack of Parents.* (Table VI)—The two children who did not have full parental protection, have already been mentioned. Maya (51) had never known her father, as he became a chronic mental patient even before she was born. Balram (54) had lost his mother in infancy and his father at the start of puberty. We have already seen that the death of the father was followed, after a quite short interval, by the first epileptic manifestations and that his complete dependence on his elder brothers seemed to form part of the situation of conflict.

One girl had to miss her father because of his frequent transfers, on which the family could not always follow him. The mothers of two children, one of them Maya (51) already discussed, were working outside the home.

(9) *Heredity.* (Tables VII and VIII).—As we have pointed out earlier, information about heredity may not be complete, as the same reasons which caused families to conceal fits even in a patient who was brought for consultation, may have prevailed in their omitting to mention some other family members who had suffered from fits.

Apart from this, however, as only few of our cases can be considered as genuine, a high rate of heredity can hardly be expected. We find the figure for incidence of all psychiatric disorders amongst relatives, with 26.3 per cent, one of the lowest in our whole material. "Specific" heredity, *i.e.* a family member known to have had epileptic fits, was only reported in one case, where one of the siblings also had convulsions. The affections of the congenital-organic group amongst the relatives exceed those of the functional type at a ratio of 1 : 0.8.

The rate for parental heredity, with 26.3 per cent, signifies that in all the families, in which any psychiatric morbidity was reported, one of the parents, possibly amongst other family-members, was affected. Amongst the fathers, we find one case of oligophrenia, one of syphilis, the psychotic father of Maya (51) and one father who was suffering from psychosomatic illness. In this same family, the mother also was afflicted by functional trouble. The other neurotic mother has been mentioned in the case history of Ismail (52).

The heaviest hereditary load seems to have been present in the family of :

- (56) *Radha*, a Baniya girl aged 5½. As one of her paternal aunts and a paternal uncle were also amongst our patients, and as each one of these patients was always accompanied by several family-members, we got, in the course of 5 years, a fairly complete picture of this joint family setting.

There was no doubt that a syphilitic infection must have had its effect at least on the generation of Radha's father. The uncle whom we had occasion to examine a spoilt young play-boy who would go into fits of stubbornness and aggressiveness, had typically deformed teeth. His sister, who visited us frequently to get some relief from her compulsive and at times catatoniform symptoms, was a crippled dwarf, possibly due to a congenital luetic affection of the bones. Radha's father was mentally dull, as the family maintained, in consequence of a fall at the age of 2. One of Radha's paternal cousins was mentally deficient. Of 3 of her own siblings, only one elder sister was living. One brother elder than her and one sister younger, had both died of infantile liver cirrhosis.

She herself, delivered by forceps and breastfed for 2 years, had also suffered from liver trouble at the age of 2. Up to that age, nothing abnormal had been noted. She had learned to walk and to talk and had even completed her toilet training. Then she started having convulsive fits. At the same time, her behaviour changed. She became restless, mischievous, uninhibited and impulsive. She would take great delight in pinching and even biting other people and in being cruel to animals.

We ourselves, during one of her fairly frequent visits, either for her own consultation or accompanying her aunt, were able to notice, how even at the age of 9, she roamed about in the whole out patients' department, entering into closed

rooms and how, with a decidedly lustful expression, she would pinch or bite the very person in whose lap she first had snuggled down affectionately. During the last few visits, 7 years after the fits had started, we were particularly struck by her interest in smelling everything. The family reported that, when one of her convulsive fits was about to start, she would hold her nose closed with the right hand, while the left arm and leg would be stretched out stiffly. Probably the fits were preceded by some olfactory aura (a premonition by the sense of smell) which, just as the abnormal interest in smelling everything like a dog, may have pointed to a lesion of the rhinencephalic regions.

Neurological symptoms, apart from an asymmetrical innervation of the facial-muscles, were not prominent.

Much of the child's uninhibited, often babyish and decidedly naughty behaviour may not have been a direct consequence of the epileptic disorder. According to the family, she had learned to use her fits as a threat to make everyone comply with her wishes. While some of the other family-members would have had the necessary understanding and firmness to discipline her, her own mother could only express her concern by excessive pampering. No consequent attempts at formal education had been undertaken. At 9, Radha was able to count automatically, but without having any direct concept of number. She could memorize quite well, but without any understanding and judgement.

The high rate of sibling mortality in the families of epileptic children, obvious without any special statistics, is actually what had caused us to investigate this factor in all groups. (Table IX). In 42.1 per cent of the families, at least one of the children had died in infancy. This figure, as well as that for the number of children who died amongst all siblings, with 25 per cent, is highest amongst all groups. One may remember, that in our general reflections, we raised the question, whether perhaps a same lack of vitality or, in other words, genetic deterioration, that led to epileptic manifestations in some family-members, may have facilitated early death in others. Furthermore, we wondered, whether the relatively low rate of psychiatric heredity might be explained by the fact that some of the family-members, who might possibly have manifested or, at an adult age, transmitted any genetic weakness, may have died at an early age. The case just quoted, that of Radha (56), shows that sibling mortality and psychiatric heredity can be associated in one and the same family. In that particular case, syphilis may possibly have been responsible at least partly. We know that, of the father's siblings, 3 sisters had also died at an early age.

Another family in which death took a heavy toll, is that of :

- (57) *Sarju*. This Hindu boy, son of a goldsmith from a small town in U.P., is the one whose parents first concealed the fits, though they had been regular features since the age of one year. It is quite possible that there may have been other cases of epilepsy in the family, but that, for similar reasons, they may have been kept secret.

Sarju was born as the second child, when the mother was aged only 15. After him, 6 more children followed. By the time we examined him, however, only he and a sister aged 6 were left, while 6 siblings had died in infancy. The boy himself showed dysplastic signs. He was severely handicapped intellectually and unable to control his emotional impulses. His tendency to perseveration and his confused talk, which contained elements that would have been beyond the grasp of a congenital oligophrenic, betrayed that the mental defect was of the nature of dementia. He had actually been able to visit school for some time, when younger, but during the last years he had forgotten practically all he had ever learned.

(10) *Number of Siblings and Position in the Sibling Row* (Tables X and XI and Graph VI).—Not only the number of children surviving, but also that of children born is relatively small in the families of epileptic children. The average number of children surviving, with 3.3, is one of the smallest, except for the .2 groups which only contain children of low age (infantilism and infantile psychosis). There are few families in which more than 5 children were born and none in which the number of children exceeds 9.

Again this may possibly not reflect the proportions as they exist in all families with epileptic children. It is quite probable that a family with few surviving children will be more ready to invest something in consultation and treatment than one in which, beside the sick child, plenty of healthy children give scope for the parents' hopes and ambitions. We have seen, for instance, that the one boy who was brought from a village, was the only surviving one out of 4.

The relatively large share of families with less than 4 children and the many deaths render the maximum possible number of special positions in the sibling row relatively high. The actual number of "special positions", however, still exceeds this figure by 15.5 per cent. Amongst the cases combined with neurotic manifestations, the excess rate is even 33.3 per cent, in other words : every single child in whom the epileptic disorder was complicated by neurosis or itself a psychosomatic expression of emotional tension, occupies a special position in his family ! Of the 6 children thus classified, two are first born, one eldest surviving, one only surviving, one eldest son and one eldest daughter. From some of the examples already quoted, one may have noted how such positions can be an additional burden on an already handicapped child, or force a slightly brain-damaged one into seeking an outlet in some paroxysmal manifestation.

One example of an only surviving child, apart from the one already mentioned, is the following :

- (58) *Prem Prakash*, aged 12, was the son of a Hindu, Kayasth, in postal service. Before his birth, 2 children had died in infancy. One more child after him was stillborn. No further conceptions followed, though at the time when Prem Prakash

was examined at 12 the mother had only reached the age of 30. While the father seemed to be a simple, calm and lenient man, the mother impressed us as very childish and insecure, clinging in anxious fashion to this only surviving child. He had been breastfed up to the age of 5 and quite generally treated like a helpless baby.

The boy had had epileptic fits since the age of four. By the time he was 12, he had certainly lost some of his mental capacities. It was, however, quite obvious, that he knew how to take advantage of the mother's overconcern. Tall, sturdy, and fat, he behaved in a clownish, deliberately stupid manner, pretending that he knew less than he actually did. According to the mother, he had not even learned to take care of his own needs. At times, however, he betrayed himself by performing a test in a way that was more difficult than the regular solution, which he obviously wanted to avoid. His drawings of human figures and birds were adorned with bizarre, superfluous additions, of which no child with simple mental deficiency or dementia would have thought.

Thanks to some homeopathic treatment, the boy had actually had no more fits for the last few months. The parents mainly came to consult us for the behaviour difficulties. We tried to help the mother to correct her harmfully clinging attitude, but the parents did not return with the boy after the first consultation.

(11). *Age of the Mother at Birth of the Child* (Table XII).—With regard to the age of the mother at birth of the child, the group of epileptic children again excels with 50 per cent of children who were born before the mother had reached the age of 20. Some of them have already been quoted e.g. Sarju (57), Prem Prakash (58), Maya (51) and Hilal (55).

One may again wonder, whether this high rate confirms the theory that young mothers are more likely to give birth to abnormal children. On the other hand, young and inexperienced mothers may perhaps be less able to protect their children from accidents and infectious diseases and, once a handicap is manifest, may be less equipped to deal with it in a reasonable manner. Only the individual case can give some clue, which of these possible factors may have been at work.

Excessively old mothers were not found in this group.

(12) *Complications of Pregnancy and Delivery* (Table XIII).—While complication of pregnancy did not play a role in any of the cases in this group, delivery was difficult, in some cases managed by forceps, in 21.0 per cent, a figure which is slightly higher than the average for all children in our material. As the group does not consist entirely of what one would call cases of "genuine" epilepsy, it is possible that birth injury may have provoked some lesion which later led to convulsive fits.

(13) *The Period of Breastfeeding*. (Table XIV).—With 15.8 per cent of children who were breastfed beyond the second year, the group of epilepsy takes third rank in this

respect. One of these children, who was breastfed up to the age of 5, was an only surviving one : Prem Prakash (58). In the others, the mothers just seem to have continued lactation up to the next pregnancy. There is no reason to assume any particular causal connection between the prolonged breastfeeding and the epileptic disorder itself ; but it may be significant that 2/3 of the children breastfed beyond the second year were found in the group with neurotic superstructures.

(14) *Toilet Training*.—Lack of sphincter control outside the acute fits, during which involuntary voiding of urine or even stool is a frequent feature, was not signalled in any case. It is, however, possible that such statements as “cannot take care of his own needs” or “has dirty habits” may have referred to lack of toilet training. Occasional bedwetting, in a child who usually can control this function, can sometimes be the first sign of epileptic fits occurring during the night.

(15) *Early Neglect and Separation*.—No case in this group seems to have been involved in any particular situation of early neglect or separation.

(16) *Parental Attitudes*.—(Graphs VII and VII a) Again, in the total group, accepting attitudes claim the foremost position, while in the majority of cases with a functional complication, overanxiousness and excessive demands seem to characterize parental attitudes. Where parental attitudes were divided, it was again the father's attitude which was more positive.

Three typical cases, in which the high ambitions and expectations of the parents may have driven the children into a state of intellectual strain and emotional tension, from which they had to seek release in fits, have already been quoted : Maya (51), the only child of a psychotic father and a working mother who placed all her ambitions on making this child go through an English school, Hilal (55), who felt crushed under his responsibility as the first-born in the family ; Suman (53), an eldest daughter. In these 3 cases, it is particularly obvious, how a unique position in the sibling-row can expose a child to strain and unreasonable parental attitudes. As in all 3 cases the fits only started at the approach of puberty, one may even wonder, whether, without such emotional tension and intellectual strain, the latent epileptic disposition might perhaps never have got a chance of manifesting itself.

One example of an excessively pampered child has been given in the case history of Radha (56).

An overanxious, clinging mother has been sketched in the case of Prem Prakash (58), an only surviving child, and in that of Ismail (52), an eldest and for a long time only son. It may be characteristic that both these children also are to be found amongst those who were breastfed beyond the second year. A further boy, also a first son after 2 daughters, who had started fits at 4, had been fed on nothing else but milk and fruit-juices up to the age of 3½, though he was a quite healthy and normally developed child up to that age.

The 2 cases whom we placed into the category of "rejection", are both eldest sons, on whom first great hopes were placed, but who became the objects of curses and death-wishes, when they were not able to come up to the parents' expectations. One of them is Sarju (57), described earlier as an example of high sibling mortality. Though he was the only surviving boy, the parents were thoroughly fed up with him by the time he was 15. Another case will be mentioned as an instance of problems of adolescence.

A case in which only the mother was rejecting, while the father tended to pamper the child, is that of :

- (59) *Farida*, a 5 year old Muslim girl. She was born after 2 brothers and 1 sister, when her mother was aged 25. After her, 3 more daughters were born. One wonders, whether the first signs of maternal rejection, which later of course found its rationalisation in the child's handicap, may already have to be looked for in an incident related by the mother : When Farida was aged 4 months, her mother had an impressive dream in which a woman came, asking her to give her one of the daughters and threatening that, if she did not comply with this request, the younger child, *i.e.* our patient, would be killed. The mother startled up from her sleep and, by her scared movements, pushed the baby out of the bed. On the day following this abrupt fall, the child had the first convulsive fit. We have heard similar stories of premonitory dreams in other cases. The mothers, of-course, generally use them to put the blame for the child's handicap and for their own rejecting attitude on some supernatural cause, while, in reality, it may be far more plausible that such dreams are already the expression of an unconscious negative attitude !

The atmosphere of superstition in this family is perhaps also characterized by the fact that, on the advice of some hakeem, the child had been fed bedbugs twice a week for a period of 6 months, as a remedy against the fits. According to the parents, this treatment had successfully stopped the fits for one year. At the time when we examined the delicate, asthenic and very anxious little girl, the fits had become more frequent, occurring at least twice every night.

(17) *Physical Defects* (Table XVI).—63.1 per cent of the children in the epileptic group were found to have either signs of dysplasia or of a damaged-brain. This rate is definitely smaller than that amongst oligophrenic (89.0 per cent) and postencephalitic (88.6 per cent) children. But the smaller figure seems to be mainly due to the relatively few cases of malformation (15.7 per cent) Neurological signs of brain-damage, with 57.8 per cent, were just as frequent as in the group of oligophrenia. This would mean that less than half of the children included in this group of epilepsy in the stricter sense are likely to be cases of so-called "genuine" epilepsy, in which the fits do not appear to be a symptom of a definite brain lesion. One has, however, to consider the possibility that some of the cases with organic signs may have been

originally "genuine", but that neurological signs may have been superimposed as a consequence of falls during fits. Some children, in fact, were found to have scars from head injuries sustained on such occasions.

(18) *Former Illnesses* (Table XVII).—Apart from pneumonia and various unspecified fevers, none of the infectious illnesses listed in Table XVII has claimed many victims amongst the epileptic children. Again one may wonder, whether this indicates a real pattern of incidence or not rather, particularly in view of the high sibling mortality rate, one of survival from such illness.

The relatively high figure for accidents includes head injuries which, as for example in Farida (59), may have been the cause of convulsions, and later ones that may have happened during fits.

(19) *Education*.—The educational attainments of the epileptic children will of course closely correlate with the onset of fits. As one would expect, Table 13 shows that the children in whom fits started after the age of 5 (in most of them only at puberty age !) had reached the highest standards in school. The 2 children with start of fits in infancy and later recurrence, had also arrived in classes corresponding to their ages, while of those who had manifested epileptic features since infancy, all girls and 50 per cent of the boys were not fit for schooling. Of the remaining 3 boys, only one was in a class normal for his age.

TABLE 13.

Educational Standard of Epileptic Children.

	Fits since infancy			Fits started after 5 yrs.			First fits in infancy, later recurrence			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Total of cases in group	6	3	9	5	3	8	2	—	2	13	6	19
No attempts at education	3	3	6	—	—	—	—	—	—	3	3	6
School failure	—	—	—	—	—	—	—	—	—	—	—	—
1st-4th class, according to age	1	—	1	—	—	—	1	—	1	2	—	2
below age	2	—	2	—	1	1	—	—	—	2	1	3
5th-8th class, according to age	—	—	—	2	—	2	1	—	1	3	—	3
below age	—	—	—	—	1	1	—	—	—	—	1	1
9th-10th class, according to age	—	—	—	2	1	3	—	—	—	2	1	3
Intermediate, according to age	—	—	—	1	—	1	—	—	—	1	—	1

Some of the examples, however, have demonstrated that, even the start of fits at a late age, can hamper or cut short intellectual ambitions. Several of the children had experienced difficulties in their studies or even given up school after having had a few fits at puberty age. Amongst the older adolescents, not included in this group

of children, we have seen several cases in which the exclusive concentration on intellectual work, particularly during preparations for exams, when often all physical exercise and recreational activities were curtailed or completely suppressed, seemed to cause a definite increase in epileptic manifestations. The person who tends to react to any strain or damage with epileptic fits, is often of the athletic type, with well developed muscles. The body, in order to function harmoniously, needs an opportunity for discharge of motor energies in the form of physical work, exercise, sports. One knows that, even in patients who have been the victims of frequent and regular fits, this incidence can be considerably reduced, if they are engaged in physical activity. The metabolic products of muscular exertion counteract certain factors in blood chemistry that favour the incidence of fits. For young adolescents, in whom aggressive tendencies may remain suppressed, physical exercise, in particular games with a note of fight and competition, provide a healthy outlet, while concentration on exclusively sedentary and intellectual work may lead to an accumulation of motor potentials, which can finally burst through in a "brain-storm".

In any child who manifests epileptic features, one should therefore rather plan a career that will involve some physical activity, though, on the other hand, one has to avoid occupations in which a sudden fall and loss of consciousness can precipitate a patient into risks to himself, e.g. by hurting himself with fire or a sharp instrument, or to the safety of others, for instance by losing control over a vehicle or some other technical equipment.

While quite a number of epileptic children can profit by opportunities for normal schooling and recreation, others may need special facilities. In those cases in particular, in which fits have started early and mental deterioration has already set in, any training should aim at teaching the child, as soon as possible, some useful manual occupation, which can be carried on more or less automatically, even when the ability for learning new performances fails.

(29) *Problems of Adolescence.*—We have already shown that the start of epileptic manifestations at puberty or pre-puberty age may, particularly in slightly brain-damaged children, provide an outlet for emotional tension. Problems of adolescence can therefore not only, as we have seen it in the group for oligophrenic and postencephalitic children, add to already existing-difficulties, but may possibly be the precipitating cause of the epileptic symptoms themselves.

We have already quoted the histories of Balram (54) who lost his father just at the start of puberty, of Maya (51), whose fits started shortly before menarche, of Hilal (55) the eldest son, and Suman (53), the eldest daughter.

One more case may illustrate the combination of problems of adolescence with an already existing epileptic disorder :

(60) *Edward*, a Christian boy of 14, was the elder of 2 sons of a Government officer. His mother was working as a nurse. Both parents suffered from some psychoso-

matic trouble. The father was absorbed in his work and showed little interest in home and children. The mother was irritable, sensitive and domineering. One of her brothers was supposed to have a brain-tumor ; a symptom of it was that, when angry, he went into fits of unconsciousness. Edward was born at term. Already after one month, the mother stopped breastfeeding and left the boy mainly to the care of an ayah, who later was blamed for anything that went wrong in the child's development. At the age of 6 months, he once had a convulsive fit during fever.

Already at 3½ years, he was sent to nursery school. For one reason or other, he had to change school several times and, though initially he was a good pupil, he gradually lost interest in learning.

From an early age, the boy showed signs of nervousness. Up to the age of 10, he would occasionally suck his thumb, chew the collar of his shirt or a corner of his quilt and, at times, shout in his sleep.

At the age of 7, he fell from a wall and was unconscious for 30 minutes. A few years later, he had another accident. Since the first head injury at the age of 7, he had occasional fits, always starting with numbness and tingling in the toes of the right foot, then stiffness and jerking of the right foot and leg, which gradually spread to the right arm and the rest of the body. The mother maintained that the first fit was only observed at the age of 11-12, when the boy tried to smoke tobacco in a pipe. This reflects her tendency to wash herself clean of any blame for not having taken proper care of the boy. We have no reason to doubt the boy's statement that the fits had already occurred earlier.

The 14 year old boy had already started shaving. In other respects too, his body was fully developed ; with his sturdy, athletic constitution, he looked older than his age. Driven by a vague restlessness, he had started becoming disobedient and quarrelsome. He had lost interest in studies and at times played truant from school, where he was supposed to attend 8th class. His parents were scared by his morbid interest in knives and guns and his occasional threats that he would kill them.

In view of all these features, which classify the boy as one of our small group of potential delinquents, the mother had lost interest in this son, in whom formerly she had already seen a future famous doctor. She began to favour the more obedient younger son and, for Edward, had nothing left but curses and death-wishes. The boy, resenting being called a "badmash" and having all his movements suspiciously controlled by the mother, became more and more loaded with anger, spite and rebellion. During earlier years, his outlet in such situations of tension had consisted in climbing trees. The physical exertion and the security and isolation of a tree-top, on which he could reflect quietly and perhaps look down in revengeful phantasies on those who made his life so difficult, had often helped

him to regain his emotional balance. Since the fits had become more frequent, possibly under the influence of increased emotional tension, the pressure on certain sensitive areas, while climbing, tended to release premonitory symptoms of fits, so that he had to give up this favourite recreation. Apart from drugs, we advised psychotherapy and guidance for the parents. As the boy, however, resented the mother's control even in coming to our Center and as, on the other hand, the mother was in no way ready to revise her attitude, while the father did not even bother to come and see us, the case also "dropped out" after a first consultation.

The question of marriage for any of the adolescents, in particular the girls, was not mentioned openly by any of the parents ; but at least in one of the girls, whose fits had started at the age of 6, and who had to stop school after 4th class, hopes and plans of this kind were most probably the reason why the parents brought her for consultation at the age of 15.

(21) *Children's Interests.*

TABLE 14.

Interest of Epileptic Children.

	Fits since infancy			Fits started after 5 yrs.			First fits in infancy, later recurrence.			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Total of cases in group	6	3	9	5	3	3	2	—	2	13	6	19
No interests indicated	4	—	4	2	—	2	1	—	1	7	—	7
Motor activity	1	—	1	3	—	3	1	—	1	5	—	5
Watching machines, vehicles	—	—	—	—	—	—	—	—	—	—	—	—
Fine clothes	—	—	—	—	1	1	—	—	—	—	1	1
Good food	—	—	—	—	—	—	1	—	1	1	—	1
Music	—	1	1	—	2	2	—	—	—	—	3	3
Noise	—	—	—	—	—	—	—	—	—	—	—	—
Playing with water	—	—	—	—	—	—	—	—	—	—	—	—
Manual occupation	—	1	1	—	1	1	—	—	—	—	2	2
Cinema	—	—	—	—	—	—	—	—	—	—	—	—
Toys, Playing	—	1	1	—	—	—	—	—	—	—	1	1
Intellectual activity	—	—	—	1	—	1	—	—	—	1	—	1

In 63.1 per cent of the cases of epilepsy, we know something about the children's interests. Motor activity, as in the previous groups, again takes first place. Passive interest in vehicles and machines was only found in the cases combined with oligophrenia and encephalitis. The active motor interests, in this group, include more organized

activities than in the previous groups *e.g.* games, sports, even participation in N.C.C. Next in frequency comes interest in music, then manual occupation, while liking for good food, clothes and toys was only indicated in one child each. Intellectual interests, apart from the regular school programme, were only specially mentioned by one patient.

This list, though rather incomplete, seems to confirm what we were just trying to explain in the paragraph on education : physical exertion corresponds to a natural need of most epileptic children, except in some cases of focal seizures, which can be released, as *e.g.* in the case of Edward (60) by certain movements irritating the sensitive "trigger-area".

(22) *Number of Visits and Possibilities of Treatment.*—(Graphs VIII and IX) The graphs indicate that, of the epileptic boys, not a single one was brought back after the first consultation and, consequently, no information about the effect of the prescribed treatment could be utilized in the graph representing results. Of the girls, 66.6 per cent returned, two even for as many as 7 consultations, and 50 per cent of the total number or 75 per cent of those who came back, reported some degree of improvement.

We have to conclude from these figures that most parents, particularly those of boys, were only out for some magic solution of their problems and not prepared to face the more troublesome method of carefully controlled medication over months or years and, even less, a revision of their own attitudes.

This is all the more regrettable as, with the available choice of drugs, one can, with some persistence on the part of doctor, patient and relatives, usually find some combination of medicines which suits the needs of the individual epileptic. At times this is even possible with quite simple remedies that will hardly cost more than 2-3 rupees a month. Dogged persistence, however, is necessary, even when success of the medication is encouraging. Furthermore, care has to be taken to control the occurrence of any possible side-effects, as *e.g.* reduction in the blood cell count, swelling of the gums or even increased irritability and moodiness. Persevering as epileptics can be in other matters, they often lack the necessary insight into their illness and the need for continued treatment. As soon as they feel a little better, they may optimistically rejoice that now the trouble is over for good and consequently forget about the medicine, while in blacker moods, they will refuse any help because they are convinced of the hopelessness of their condition. Unless some family member with the necessary authority can keep strict control, not only over the medication, but also with regard to diet (often salt has to be reduced or replaced by medicinal salts !), and general regularity of daily life, any advice may be quite futile.

In the West, most countries have special institutions for epileptic children, either for short-range treatment and habituation to a certain healthy routine, or for long-range training or, in the most deteriorated cases, for life-long care. Children with frequent sudden fits or with a tendency to roam about in a state of altered consciousness, when left without adequate care, can not only easily get into situations dangerous to

themselves, but may shock their playmates and class-fellows by the dramatic seizures or even harm others while not in full control over their impulses. For them, treatment and special education at residential institutions may provide the only chance of growing into an at least moderately useful adult.

Once the superstitious view about epilepsy, which still seem to be deeply rooted in many parts of the Indian population, will yield to a more rational understanding, the demand for special facilities for these patients will no doubt increase. It might be wise to start already now to gain experience and to train specialized staff, so as to be ready, when this problem comes to a point of greater urgency. Since this chapter was written, an interesting development has taken place in this respect : A Sub-Committee of the Mental Health Advisory Committee of the Ministry of Health has been set up to investigate the possibilities for establishing special "Epilepsy Clinics" in various parts in India. It is to be hoped that the recommendations of this Sub-Committee can soon be put into action and that, as a consequence, increased attention and suitable treatment can be given to the growing number of epileptics brought to the various neurological and psychiatric services.

5. Other Organic Cases.

It is with a certain embarrassment that we have to present, in a separate group, the small number of only 5 cases : 3 Indian, 1 Anglo-Indian and 1 foreign, who presented organic disorders that could not easily be placed into any of the other 3 categories of the congenital-organic section. A different classification, a slightly wider definition of one group or the other, might perhaps have allowed to avoid this further splitting up of our material. One will, however, see that, though the few children in this group all present one or the other feature that might match one of the other groups, each case also has its peculiarities which deserve separate mention. As even amongst themselves these few cases do not have much in common, except the fact that they all show signs of organic brain damage, the best thing will be to present them individually, without any attempt at summing them up by percentual figures, which would have hardly any value.

- (61) *Vinai*, a 7½ year old Hindu boy, was brought for congenital deaf-and-dumbness. As there was nothing much we could do for him, he was referred to the ENT Department of Medical College. No detailed information was collected.
- (62) *Arun*, a Hindu boy from a town in U.P., also was unable to speak at the age of 9, but he definitely could hear. He was quite bright, intelligent and quick and skilful in motor performances. He had learned to take care of his own needs. At a school for deaf-and-dumb children, he had been taught to write a few words. The association between hearing and writing seemed to be intact. He would, for instance, quite promptly write "cat" or "dog", when the usual voice of one of these animals was imitated before him. He could utter some inarticulate sounds, but only few recognizable words, though quite obviously he tried hard. On the other hand, however, he seemed to have learned to take advantage of his

handicap by ordering, with gestures, that others should put on his shoes, button his pants etc., all acts which he was quite capable of performing himself. The family apparently encouraged him in these manoeuvres by their pampering attitudes. All signs pointed to a cerebral disturbance of speech of motor or subcortical type. As to the origin of this defect, the boy's history offers a whole choice of possibilities. Heredity is heavily loaded : One paternal great-uncle had had epileptic fits. A maternal great-aunt had suffered from mental illness. Neither of the parents presented any mental deviation. The father was principal of a college, quiet and reserved, but a strict disciplinarian. The mother, gentle and affectionate, seemed to be particularly attached to Arun. His eldest sister, aged 22, was mentally deficient. The next-born brother, a student, had consulted us, already before Arun was brought, for epileptic fits, which had started in late adolescence, probably with a good dose of emotional tension involved. A next sister was normal, while the fourth child in the family, a boy, also had epileptic fits. The brother next elder to Arun, at the age of 12, presented nothing pathological, except for a certain mental slowness. One sister younger than Arun had epileptic fits.

Arun himself had a severe attack of influenza at the age of $1\frac{1}{2}$ years, which left him weak. Already before that, however, the parents had noted that the child did not seem to react to sounds like the other children. From the age of 2 up to about 6, he occasionally had convulsive fits during high fever. At the age of 5, he did a fall, followed by unconsciousness during 15 minutes. We thus have factors that point to a hereditary disorder, while infection (influenza encephalitis ?) and trauma might also have contributed their share. One might, in view of the heredity, perhaps have done right to classify his case in the epileptic group. As, however, fits of epileptic nature had never been in the foreground and even had been completely absent during the last 2-3 years, we felt justified in mentioning the case separately.

(63) *Walter*.—Somewhat similar features characterized an American boy, whom we first examined at the age of $3\frac{1}{2}$. His parents were worried, because he still had not learned to speak and, though he definitely could hear loud noises and music, showed no signs of responding to speech. At times he was irritable and went into temper-tantrums and then again behaved like a small baby, wanting to be petted and pampered. These American parents, contrary to many Indian ones, were also concerned about the fact that, at the age of $3\frac{1}{2}$, the boy still occasionally wetted his bed.

The parents were both rather nervous, overanxious and pedantic. The boy's maternal grandmother had died of a brain infection after sinus trouble. One maternal uncle, as well as the paternal grandfather, were described as excentric and unstable characters.

An eldest child, born 2 years before our patient, had to be operated for a brain abscess. At the age of 22 months, she had not learned to walk and talk yet.

Just 2 weeks before our patient was born, this girl died after a second, unsuccessful brain-operation. The mother then concentrated all her anxiety on the newborn baby, and it seemed highly probable that any organic damage to the cortical area or associative pathways related to speech had been accentuated by the boy's emotional reluctance to communicate by talking. When the boy was aged two, a younger brother was born. This seemed to provoke his jealousy, and the behaviour difficulties increased. At the time when we first saw Walter, the mother was pregnant again and some time later gave birth to another boy.

During 13 visits, distributed over a period of 5 months, we had occasion to observe the boy and to guide his parents. While, in the beginning, he manifested certain compulsive features, probably a result of the parents' pedantic discipline, he learned to relax in the permissive atmosphere of the play-room, and, at times, became quite boisterous. When he forgot himself in play, he often would suddenly shout or even exclaim a few words. Occasionally, after he had grown familiar with the therapist, he would even come and, with a quite mischievous smile, whisper something into her ears. Rhythm and intonation of these little, 'messages' had all the expressiveness of real speech, but lacked any recognizable words. When treatment had to be interrupted, as the family left Lucknow, both, parents and child, had become far more relaxed, and the boy was more ready to use what little speech he was capable of.

Four years later, we again saw Walter. According to the parents, electro-encephalographic investigation at a clinic in U.S.A. had given some pathological results. With a hearing aid, the boy was better able to communicate ; speech, however, was indistinct and obviously costing him some special effort. More than at the age of 3½, one could now observe some other signs of brain-damage. The boy still presented some compulsive features ; but the parents were proud of his slow and systematic perfectionism.

Heredity, in this case, indicates a special susceptibility of the central nervous system to infection. In the patient himself, however, congenital brain-damage seemed more likely.

(64) *Avinash*, the fourth case, might perhaps have fitted into the category of postencephalitic children. He was the eldest son of a Hindu chemist, born after 2 sisters. 2 brothers were younger. All siblings were healthy and developing normally. The older ones were doing well in English schools. No psychiatric illness was known of in the wider family. Avinash was healthy and lively up to the age of 5. At that time, after already having attended nursery school for 1½ years, he fell ill with jaundice and high fever. After this illness, motor restlessness, and definite tics of the facial muscles were noted. At the same time, he became stubborn, quarrelsome, aggressive and destructive.

When we examined him at the age of 7, the tall, slim boy was constantly moving and fidgeting. His face was frequently distorted by violent tics, and his hands

performed athetoid (twisting) movements. His legs and feet were slightly deformed, his eyes squinting. Speech was badly articulated and unrhythmical. Quite generally, he lacked motor coordination. During purposeful movements, when he was interested in some activity, he could occasionally be quite skilful, and the facial tics would then become milder. More often, however, his play would be quite uncoordinated and destructive. The nervous trouble presented by this child is most likely of the type called "Chorea minor", which is supposed to be the consequence of a rheumatic affection of the brain. The exact nature of the febrile illness after which the symptoms started, is not known. The jaundice may have been due to hepatitis, *i.e.* a virus infection, which can be followed by brain-damage of the type of hepato-lenticular degeneration. On the other hand, infantile liver trouble and an infection of some other type might have existed together. Possibly the originally purely organic symptoms may have been exacerbated by emotional factors, due to excessive pampering during the acute illness and exaggerated parental demands during the time of convalescence. As this boy too came for one consultation only, we had no opportunity for further investigation.

The last case classed separately in this small group, is that of the Anglo-Indian girl quoted in the general part :

- (65) *Pamela's* mother had German measles (rubella) during the second month of pregnancy. As already mentioned, the 5½ year old child was deaf, almost blind, had atrophic and deformed limbs and an incompletely developed heart. 3 brothers were healthy, and no other illnesses of the nervous system were known of in the family.

One might have accommodated this case in the postencephalitic group. In view of the very particular aetiology and the presence of severe dysplasia, motor and sensory disturbances, however, it seemed to deserve special mention.

5. Neurosis.

(a) *Definition and Differential Diagnosis.*

While, up to now, emotional disorders have only interested us as far as they had superimposed themselves secondarily on affections of the congenital and organic type, the chapter on neurosis leads us into the midst of what we have summed up as the "functional" group.

By functional, in contrast to organic and congenital, we mean a deviation from the norm which does not have any anatomically or histologically demonstrable lesion or malformation as its physical substratum, but which results from a lack of balance and harmony in the use of initially normal structures and processes. Where, however, any structural weakness or damage is already present, it may be built into the distorted function. The physical deficiency and the lack of functional harmony may then

mutually increase each other. Similarly, if a function has been misused for some time in a gross manner, it may finally even affect the anatomical structure itself.

Already in the chapter on diagnostic categories in the general part, we have pointed out that the term "neurosis" for the group of children designated by it, might not meet with general approval of other psychiatrists. As, during childhood and adolescence, everything seems to be plastic, fluid, subject to constant transformation, deviations from a certain norm at any given moment may have a very transitory character and may therefore give less cause for concern than the same symptom might justify, if it appeared at a later age. We need not even consult learned modern books on psychology and psychiatry to find this truth stated. One of India's greatest poets, Rabindranath Tagore (20), has given an admirably clear formulation of it in his "Reminiscences", which certainly deserves to be quoted here : "...the mistake is to judge boys by the standard of grown-ups, to forget that a child is quick and mobile like a running stream ; and that, in the case of such, any touch of imperfection need cause no great alarm, for the speed of the flow is itself the best corrective. When stagnation sets in, then comes the danger." He adds, from his point of view of a man interested in education "So it is for the teacher more than the pupil, to beware of wrongdoing." If, for our own purposes, we substitute "parents" for "teachers" and "children" for "pupils", this last statement already sums up many of the problems which we shall find in our neurotic children.

As many of the children examined were brought years after the first signs of a distortion had been noted, (see Table 16 in paragraph on distribution according to age) the point of the dangerous "stagnation" or "fixation" which freezes one or more of these frequent temporary childhood whims and fancies into a rigid habit, may already have been passed, and they may deserve the designation "neurotic" even in the eyes of those who use this term very sparingly. Even then, there remain quite a number of cases in which some disorder, *e.g.* some anxiety, was of fairly recent origin or in which the great variety of symptoms indicated a flexibility that had not been narrowed down yet by the definite choice of a well established particular form of neurosis.

One might perhaps have renounced any classification that attempts to group cases according to theoretical notions and, instead, one might have used the more descriptive terminology in which some clinics present their statistics. Delhi Child Guidance Clinic, for instance, in its annual reports (5), gives a loose enumeration of problems such as "speech difficulties ; nocturnal enuresis ; scholastic difficulties ; functional fits ; vague aches and pains ; food fads, anorexia etc. ; stealing, lying and truancy ; functional motor disorders ; stubbornness and disobedience ; psychogenic vomiting of food ; aggressive, violent and destructive behaviour ; functional headaches and respiratory trouble ; temper tantrums in pre-school age ; fears and phobias ; persistent and prolonged thumbsucking ; obsessive behaviour", to name only those categories which presumably denote functional disorders.

In the annual report of a Swiss out-patient department for child psychiatry, (Psychiatrische Poliklinik fuer Kinder und Jugendliche, Basel) an attempt at grouping the individual problems into 3 categories is made : 1. irregularities of development containing various forms of infantilism, crises in the "age of spitefulness" (*i.e.* at the age of 3—5), crises in puberty. 2. Psychogenic reactions, with the sub-groups anorexia, difficulties in nutrition ; depression, anxiety phobias ; enuresis and enkopresis ; stammering and other speech disturbances ; pavor nocturnus, somnambulism ; masturbation, sexual disturbances ; hysterical reactions ; waywardness ; other reactions to environmental influences. 3. Psychogenic development or neurosis in the strict sense. Hypermotor symptoms like tics, psychosomatic disturbances, juvenile delinquency and schizophrenia are listed separately. The clinical department of the same service, lodged partly in the children's hospital, partly in special observation centres, however, lists its statistics under a different set of headings, taking as "psychogenic reactions" only : spitefulness, depression and anxiety and "other unspecified ones", while most of the problems enumerated as "reactions" in the previously quoted list, figure as "psychogenic developments". One may assume that children who need clinical treatment either at a hospital or a residential observation home, present more rigidly fixed symptoms than those brought for out patient consultation only. As here in India, however, the public is not accustomed yet to the use of such services, even where they exist, and as therefore most cases are only brought when severe symptoms have persisted over a relatively long time, we have to assume that the cases examined at our Psychiatric Center in Lucknow would more or less correspond to the serious ones which, in the West, are considered as being in need of residential treatment.

The author who has worked in both, the Swiss out-patients' department just mentioned and at the Lucknow Psychiatric Center, has indeed been impressed by the fact that, in general, children brought for consultation here in India, present much more severe and longstanding disorders than the ones examined in the West. We may therefore be justified in presenting our series of functional disorders under the heading of "neurosis", even at the risk that a few of the cases might better be characterized as a temporary crisis or reaction. One will only have to keep in mind that the term "neurosis" in this connection is used in the widest sense, perhaps rather meaning "neurotic features" than fully crystallized neurotic structures, and that its main purpose is to delimit a certain group of psychological deviations in childhood and adolescence, on one hand against organic disturbances of congenital and acquired type, on the other hand, within the functional section, against conditions that already suggest a psychotic process.

While the delimitation against organic and congenital states is the same as that already given for the functional disorders in general (see page 162), the differentiation from the other sub-groups in our functional section, already sketched out in the general part, may have to be stated once more :

Again we have to face the fact that the division, as it has been attempted here, into "neurosis" (in the sense of neurotic features), "infantilism", "infantile psychosis"

and "adolescent psychosis" may not meet with the universal consent of workers in the field of child psychiatry. If we compare again with the diagnostic list given for the out-patients' department for child psychiatry at Basel, our group of "infantilism" would coincide with a corresponding sub-group of this category "irregularities of development", including states in which physical, intellectual and emotional development are uniformly retarded. The other two sub-groups of this category : "crises at the age of spitefulness" and "puberty crises", might possibly contain some cases similar to what we have labelled as "infantile psychosis" and "adolescent psychosis". From her experience at the Basel clinic, however, the author knows that cases of severe autistic withdrawal or symbiotic clinging, as we have seen them amongst children here in India, and also full-blown psychotic reactions of catatonic or hebephrenic type, as included in our group of "adolescent psychosis", are much rarer amongst Swiss children of the corresponding ages. It is more likely that any such cases have been included under the heading of "schizophrenia", which forms a negligible share of 2 per cent at most for out-patients and up to 5 per cent in the residential institutions. This latter figure, may, however, include male adolescents up to the age of 18 and, since a new observation center for adolescents was opened a few years ago, an accumulation of difficult cases from all over the country.

In our material, the cases of adolescent psychosis alone, for all-5½ years taken together, amount to 6.2 per cent, those of infantile psychosis to 8.1 per cent, *i.e.* all cases diagnosed as psychotic together account for 14.4 per cent of the total material. If we further consider that the cases brought to our Center are probably only a small fraction of all similar ones, while the Swiss clinic is more likely to get most of the existing cases of this kind, one would have to conclude that psychotic reactions in childhood and early adolescence are more frequent in India.

The annual reports of Delhi Child Guidance Clinic, limit themselves to cautious headings of "schizophrenic trends" (2.7 per cent in 1956-57) or "paranoid and schizoid tendencies" (1.6 per cent in 1955-56, 2.8 per cent in 1959-60, 3.4 per cent in 1960-61).

As facilities and sources of referral are different in all 3 clinics, the figures can hardly give any clue which would allow to decide, whether the term "psychosis" or "schizophrenia" has been used in a wider or stricter sense in one or the other. From her experience, however, the author, having viewed the cases in both, the Swiss and the Indian psychiatric clinic, with practically the same diagnostic criteria, feels entitled to maintain that the greater figure of psychotic children and adolescents in the Lucknow material is not the result of a slacker use of the terms, but of an actual difference in incidence of such cases.

Most authors would probably admit that the differentiation between a merely "neurotic" case and one that deserve the label of "psychosis", is, at least partly, a matter of intuitive impression, and that any enumeration of neatly classified distinctive symptoms may merely serve to give a rational and communicable form to this primary awareness of being affected by the patient's behaviour in a certain way. While the

particular symptoms that positively characterize the various conditions which we have included in the psychotic groups will be given later, we have to offer, in this connection, at least an attempt at establishing a fundamental distinction between neurotic and psychotic manifestations.

If we go back to our characterisation of functional disturbances as a "lack of balance or harmony in the use of originally normal structures and processes", one may ask first, what causes can lead to such misuse, but also, what purpose the distorted function may have to serve.

While, for a long time, psychosis, more than neurosis, was supposed to be based on definite hereditary factors, research during recent years has rendered it probable that environmental influences also play an essential role in its genesis. A fundamental difference, however, is seen in the period of life at which the child is exposed to a harmful environment. Psychosis, in most cases, is supposed to date back to disturbances in very earliest infancy, to a period at which the distinction between "I" and "not I" is not made yet, and at which the intimate, empathic relationship with the mother constitutes practically the whole world for the child. Any disturbance in this close relationship, which in one case may perhaps be rather due to the child's excessive sensitivity, in another one more to a faulty maternal attitude, may leave a permanent weakness of what one often calls "ego-boundaries", the ability to identify oneself as a separate unit, faced by a so-called "outside world".

The neurotic, on the other hand, seems to develop fairly normally up to the point at which he emerges from the merely empathic-symbiotic type of early infantile existence. He attempts to establish his limits, to come to terms with "outward reality", but, due to stress between his inward disposition and the requirements and pressures of this "outside world", he has to use much of his energy and his "functions" in the service of defence against or compromise with that which meets him from the outside. Again one might say, as we tried to formulate it earlier, that the ability to transform the "outside world" into one's own substance, to receive it into oneself, is constitutionally weak or has been impaired by certain shocks or frustrations. Influences from the "outside world" therefore have to be shielded off, neutralized, transformed or constellated in a manner that helps to keep up internal equilibrium.

(One will note that, in this context, as also in later passages, terms as "outside" or "outward world" and "inward world" have been put between quotation marks. This is a caution meant to ward off the reproach of all too naturalistic-materialistic thinking, which imagines a human being as a tightly closed unit faced with an entirely separate objective world. Newer philosophical and psychiatric theories in the West stress that no such limit can be established, but that man, right from the beginning, exists "in-the-world", so-to-speak "outside himself". But even authors who adhere to the existentialist school of thought and its terminology, find themselves faced with the fact that the average human being experiences—or perhaps "misunderstands"—certain portions of the world as "outward", while others belong to an "inside". One

solution seems to be to differentiate an "own" or "private world" from the "common world" ("Eigenwelt" and "gemeinsame Welt" in German), which latter would more or less correspond to what, in Hindi and Sanskrit, is called "vaishvanara". The terms "inside" or "inward" and "outside" or "outward", as used by the author, are mostly meant to differentiate that which an individual has already consciously assimilated, *i.e.* "made his own", from those parts of the world which he still meets as "strange", "other than himself" and which, like the physical food, first have to be "ingested, digested and assimilated". The concept of old Indian philosophy, that everything is "anna", *i.e.* food, opens interesting prospects in this connection !)

The main point of distinction between the neurotic and psychotic then may be that the former has established a certain differentiation between an "I" and "not I" and that his symptoms and reactions are in the service of keeping up contact with an "outside world", though this very contact may have to be padded off or carefully filtered through thick defensive layers. The symptoms of the psychotic, on the other hand, seem to aim at denying and obliterating these very ego-boundaries which the neurotic works into a defensive wall. This may be achieved either by leaving everything open without any clear distinction between the "inside" and "outside", or then, rather paradoxically, by the establishment of an extra-thick wall. This wall, however, no longer serves purposes of communication, but aims at shutting out altogether, whatever may threaten to stir one into having to recognize anything that has separate existence and which therefore might "affect" one. A kind of pseudo-communication will of course still be kept up ; but on closer study of its nature and motives, one will find that the object or partner of this communication is not experienced as something existing in its own right, but only as a representation, a complement or possibly a convenient "symbolic" expression of one's own subjective needs and tendencies. One may compare this type of entirely subjective or "autistic" existence to dream-life, where also we do not give existence to dream figures as independent beings with their own consciousness, but only as a convenient symbolic formulation for our own internal needs and tendencies.

One will realize that the problems thus formulated, remind one of certain fundamental views about human existence as found in the classical Hindu scriptures. This is not the place for going into the deeper implications of this resemblance between a pathological autistic withdrawal and certain practices and aims of spiritual aspiration as recommended by Hindu philosophy. What may, however, interest in this connection, is that philosophical ideals of this kind may not only have originated in a people with a particular constitution, but may also have, through many centuries, reinforced certain modes of reaction and of existence, which, if thrown out of balance, may result more easily in a total break with "outward" reality than in an attempt to filter or modify the dangerous influences through neurotic defence structures. We may have to come back to this question, when we have to explain the striking difference in distribution between Hindus and Muslims in the neurotic and psychotic groups amongst our children.

For the moment, our purpose of delimiting neurotic reactions and developments against psychotic manifestations may be served by the somewhat crude statement that,

in the neurotic, misuse of functions stands in the service of maintaining contact and exchange with his surroundings, while the psychotic coordinates his functions, in a distorted manner, to his need for denying the existence of an independent world outside himself. He may seek complete union in merging or isolation behind an "iron curtain", but not communication, which always presupposes the recognition of two subjects.

One major distinction, which one might perhaps easily have covered with silence, still has to be made : In Western literature, except perhaps that of most recent years, the concept of "psychopathy" plays a great role. Continental European authors in particular, have devoted great care to describing the various pathological types of personality, which they considered as constitutional deviations from a certain norm. Gradually, however, particularly in Anglo-Saxon countries, this static view was loosened up by more dynamic reflections. Psychopathy was supposed to be, like neurosis, due to an acquired distortion, though possibly on the basis of a certain constitutional bias.

As, however, one still was faced by the fact that there were doubtless fundamental differences between patients who strike one as "psychopathic" and the so whom one would like to term as "neurotic" other criteria for distinction had to be found. Certain authors then gave the definition that a neurotic suffers within himself, while the psychopath, rather in paradox to what the name implies ! (i.e. one who suffers with his psyche or in whom the psyche suffers !)—makes others suffer. This formulation, though perhaps it does not quite apply to all types of psychopathy described by the continental authors, serves very well for practical purposes, *i.e.* in characterizing certain criminals. One finds, in fact, that the neurotic usually does not feel comfortable within his skin. He knows that something is wrong with him and is glad to find help. The psychopath on the other hand, seems to have solved his problem by ways of behaviour that leave his internal equilibrium undisturbed, and he remains quite unconcerned about any upsetting effect he may have on his surroundings. He does not experience any lack of balance within himself, has no sense of illness, and therefore is very unlikely to seek and accept help.

In recent years, as the influence of very early and subtle environmental factors has been more and more recognized, the term "psychopathy" has been used more sparingly and cautiously even in continental Europe. In the annual reports of the department for child psychiatry of Basel University, already quoted several times, the designation "psychopathy" still figures quite regularly up to 1957. In 1959, it makes one more timid appearance, while, after this year, it seems to have been exploded or dissolved by more dynamic views. The fact, however, that the statistics for adults, for the mental hospital as well as for the out-patient department of this same psychiatric service, still mention considerable numbers of psychopaths, even in 1961, may mean that the more dynamic and optimistic concept has only been accepted for the periods of childhood and adolescence with their particular plasticity and variability, while for adults the idea of a "frozen" abnormal character structure is still recognized.

The author must now confess that, though during her psychiatric work in Switzerland, she had no hesitation to use the term "psychopathy", she has not dared to apply this diagnosis to a single one of her over 1600 Indian patients ! Psychopathy, more perhaps than any other psychiatric concept, can only have a meaning, if one accepts a definite "norm" for human behaviour. The "psychopath", in his static condition, neither differs from what he once has been nor from what he aspires to be or from what he feels he should be. The only term of comparison then is a socially defined and accepted norm of human behaviour which others apply to him.

As a foreigner in a country with different culture, however, one has no right to apply the norms of one's own accustomed background. On the other hand, to gain a true estimate of what the guest country considers as a norm, might only be possible after years of close observation and identification. While this difficulty would present itself to a moderate degree even to a foreign observer in a country with cultural values fairly similar to his own, it assumes enormous dimensions, if one changes from a Western European setting into a country as far apart as India. The puzzling difference, furthermore, is not only that between the guest country and the original environment, but it is enhanced by the multiplicity of different cultural patterns and social norms within the country itself, which displays a wealth of variations according to climate, geographic conditions, racial origin, religious communities and social distinctions. Even beyond this,—and this may be the most conclusive argument against using the concept of psychopathy as a constitutional deviation from a norm on Indian patients,—the attitude of the predominant cultural group, the Hindu community, is characterized by so wide a recognition and tolerance for all human possibilities, that the establishment of strict norms of human behaviour, apart from a few rules of social hierarchy and a code of manners lubricating the peripheral surfaces of human contact, can hardly be thought of.

One might argue that, at least according to the definition favoured by Anglo-Saxon authors, psychopaths as people who, by their deviations, make others suffer, could be recognized even in the permissive Indian setting. If one measures by Western standards, one might find people of this kind not only amongst one's psychiatric patients, but, quite frequently, also in everyday life. Again, however, if we consider, what the traditional Hindu attitude would be, we have to admit that even this distinction would hardly hold good. In a rather extreme formulation, one might say that, according to certain ideas of Hindu philosophy, no one can harm anyone or make anyone suffer but himself. Whatever anyone does, may seemingly find a target in some other person or object. The main effect, however, will come upon the doer himself, through his "karmic" entanglement, while the other person seemingly harmed, again will only be affected according to the degree of his own involvement in the bondage of "karma". The logical consequence then would be that anyone who has reason to feel "harmed" or "annoyed" by the behaviour of a person who, according to Western standards might be regarded as psychopathic, would not so much direct his concern towards diagnosing

and perhaps attempting to correct this person's abnormal character, but rather examine himself for weaknesses by which such outward influences can still gain a hold over him.

Though in practice extreme attitudes as the one just sketched may no longer determine human relationships in India as decisively as perhaps in the classical periods of Hinduism, the imprint which doctrines of this type have left on the Indian psyche through hundreds or even thousands of years, can still be recognized in many situations. Whatever may be left of this attitude nowadays, would certainly provide a powerful argument against the use of the term "psychopathy" even in its moderated Anglo-Saxon meaning.

While, thus, we have tried to delimit the group of children with neurotic features against what it "is not", we shall leave the description of what finds place inside the group to the following paragraphs.

(b) Causes and origin.

Neurosis is counted amongst what one calls "psychogenic disorders", *i.e.* morbid manifestations that take their origin within the person's psyche. This term, however, is meant more in contrast to "organic" as indicating a primary physical lesion, and does not exclude environmental influence of a psychological type. On the contrary, even conflicts which, at a later stage, may appear as entirely intrapsychic, may originally have taken their pattern from outwards constellations and influences.

Again, as we had shown for some of the organic affections, in particular epilepsy, a constitutional weakness and environmental influences can complement each other in varying degrees. A more sensitive child with little capacity for either warding off, enduring or assimilating what he meets in the "outside" world, is adversely affected and forced into a neurotic defence by circumstances which would leave a more robust child unshaken. Even a tough constitution, however, can be warped and wounded by persistent harmful influences of a very drastic kind. Again, the harmfulness of various factors in the environment may not only vary with their quantitative degree, but children of different dispositions may be sensitive to experiences of a quite different quality. As the proverb goes: "One man's meat is the other man's poison." In whatever way an initial outward situation may act on a constitutional readiness, the drama will gradually shift from a mere involvement with an "outside world" on to an inner stage.

Various psychoanalytical theories have tried to distinguish the conflicting parties within the human psyche by delimiting certain "areas", as *e.g.* the "conscious" and the "unconscious", by defining certain "forces" as "ego", "id" and "superego", or by describing "archetypes" and "psychic organs" as the figures of the internal drama. While such formulations may have their value as metaphors and symbols, they risk to seduce one into a rigid, concretized mode of thinking, which can never do justice to the ultimate fluidity and formlessness of human potentials.

Certain European psychiatrists, who base their views on the concepts of the existential philosophy of Martin Heidegger [See *e.g.* Boss (21) and (22)], have tried to loosen up these mechanistic concepts and to bring them into harmony with the philosophical view of human existence as openness to the world or as a sphere of light into which all that is met with can appear and come into its true being. Openness and light, however, have as their counterparts "closedness" "mystery", "darkness" or "shadow", concepts which certainly come far closer to those of classical Indian philosophy than the all too mechanistic systems of Freud and even Jung and some of their followers. Furthermore, an attempt at conceiving problems of mental illness in terms of openness and closedness, of capacity or failure to lighten up a world, brings us again to the formulations which we have used to characterize an essential weakness not only at the root of functional psychiatric disorders, but which may also be the basic defect in the crippled human existences of oligophrenics and epileptics : A limited openness, an inability to keep the clearing of light and order free from invasion by the jungle of darkness and chaos, or a failure even to develop any power of illuminating within oneself, so that one's existence may depend on receiving light from some other source ; or, as we tried to express it, in a formulation not quite acceptable to "Daseinsanalyse", an inability to receive the world into oneself, to make it one's own, to "become" the world instead of merely "having" it or being opposed and hostile to it. One will realize that all these attempts at formulating something that is really elusive beyond any form, at least abstain from assuming an eternally impassable gulf between subject and object and also avoid thinking in terms of frozen structures, such as "psychic apparatus", and the whole anatomy of "intrapsychic organs, layers and levels", which all too easily suggest localisation of definitely shaped "parts" and calculable "forces" in corresponding containers and channels. Understanding, what older theories characterized as "the conscious" and "the unconscious", not as something that has fixed limits and perhaps even something like a "localisation" in the basement or cellar of the human psyche, but as a constantly changing play between disclosing and closing, revealing and concealing, light and darkness, openness and mystery, remembering and forgetting, opens a view more dynamic than the most vigorous "psychodynamic" theories. It makes one, in fact, think less of Western psychological systems, than of the eternally shifting veil of Maya, which conjures up forms out of the formless and lets that which has assumed shape and action again dissolve into pure potential.

The problem then may be that, in order to take in this world, which first meets us as something "outside", we have to keep open to it, even if this exposes us to discomfort and pain ; on the other hand, if we want to keep out what we are not ready for yet, if we want to assimilate, to make our own, what we have allowed to enter, we also have to be able to close ourselves so as to create the firm vessel within which the process of mixing and transforming can take place. We want to conserve our identity, the particular "thatness" of our existence, and yet, we have to take our nourishment, our stimuli, our support, from that which is different from us. On one hand, being active, dealing with the "hard realities", requires that we should allow ourselves to adopt some form which can stand contact and friction ; growth and maturation, on the other

hand, can only be guaranteed by remaining fluid and unconfined. Or expressed in still other words : we have to guard against accepting as belonging to ourselves only that which has assumed a definite structure; but also, in order to contain the very potential that is our future and therefore the most living force in us, we have to develop firmness and power of concentration. While the aim is to become pure light, we must realize that no light is visible unless it falls on something that is not entirely permeable for it ; we must therefore accept obstacles that block our way and that cast shadows as the very condition that allows us to become aware of the light.

Finding one's ideal middle path between all these contrasting necessities, may indeed be a rare chance, and we need not wonder, if conflict and confusion, attempts to shelter from terrifying openness and exposure and, at the same time, of avoiding suffocation within a tight shell, lead to all kinds of compromises and defensive devices. If they freeze into permanent shape, we can call them neurotic distortions.

As, in the West, the accent, for centuries, has mostly been on form, on individual integration and firm structure, fit for meeting "hard reality", in efficient activity, many psychiatric syndromes there are characterized by the thick crust of defensive armour that has been built round the living core of human existence. The therapeutic process, therefore, has to consist mainly in a loosening, an "analysis" of compact, "complex" structures. The East seems to have favoured openness, relying on being held together by the particular structure of society rather than by any own individual boundaries. The danger therefore may have consisted, at least up to the recent invasion by Western ideals and ways of life, in a disintegration, an inability to contain, rather than in an excessive walling in of the separate individual.

The emergence from a predominantly empathic-symbiotic form of life into one of individual responsibility, however, brings with it the necessity for some kind of a protective "skin". If the all too sudden need for facing this different kind of society does not allow time for growing a living membrane, which guarantees not only protection, but also exchange, a rigid, lifeless crust may be precipitated, under which life and capacity for growth are suffocated.

The particular form which the neurotic defences and compromises take in individual cases, may partly depend on the conflict situation, partly on constitutional factors, but may, perhaps just as much, be determined by what the surroundings will accept as manifestation of illness and as an excuse from certain responsibilities and activities. While, in the Western patient, according to the generally greater rigidity of personality structure, one straight channel is often chosen right from the beginning and kept up with a certain consequence, the greater plasticity characteristic for Indians often expresses itself in a great variety and variability of symptoms, reminding one at times of the many exits a fox has to his burrow. Gradually, after a phase of experimenting with various "solutions", a patient may, however, stick to the one defence that does not only suit his disposition best, but which also promises either to reveal or to conceal

his weakness in just the particular way which will, to an optimal degree, ensure the necessary support and avoid loss of respect before the persons of his environment.

While certain symptoms seem to aim more at revealing, others, on the contrary, tend to conceal any weakness or conflict, not only before others, but also before the patient himself. The choice of symptoms within this range of greater or lesser openness, the extremes of which can perhaps be seen in a dramatic hysterical scene and a psychosomatic illness deeply buried in an innermost organ, seems to depend on the strength of the forces that aim at suppressing any awareness of conflict. These forces again can be internal ones, what one might call "health conscience", certain notions about having to appear fearless and having to preserve "mental balance", but they may also be represented mainly by outward standards and expectations. Where, for instance, a hysterical demonstration is still taken as a manifestation of possession, investment in a symptom of this type not only allows a considerable release of energies, but at the same time absolves the patient from all responsibility for the occurrence, not only in the eyes of others, but also before his own conscience. Where, however, hysterical manifestations have been debunked as "not quite honest" and rather shameful, the conflict has to find expression in a less superficial and obvious symptom. In the West, probably under the influence of the exposure of all kinds of symptoms by popularizing psychoanalytical literature, the need for repressing and concealing seems to drive people more and more into psychosomatic manifestations far removed from the control of consciousness. On the other hand, one finds colourless states of apathy and nihilistic despair, in which hardly any definitely shaped symptom can be accused any longer of revealing, what one has to hide from oneself and others.

Here in India, where information about psychoanalytical theories is still limited to a small group, and even there, often consists more in a merely intellectual registration in a "watertight compartment", and not in any living knowledge, one finds in general that neurotic and psychotic symptoms are still far more colourfully revealing than the expressions of similar conflicts might be in Western patients.

One can perhaps say that, the more acute the conflict and the less any fear of being exposed as weak, cowardly or shirking before oneself and one's surroundings, the less care will be taken to develop a deeply concealing symptom. In form of a parable, one might illustrate this statement as follows :

Suppose a man has collected a treasure. If now he is suddenly warned that dacoits are about to raid the house, he may not have time to find a really secure hiding place and may therefore have to remain content to bury the treasure just below the surface of the ground. If the danger has been an exceptional one, unlikely to recur, the treasure can come out into the open again. If further attacks are to be expected, a safer method of concealing it can be found. If, however, the threat is permanent, but not of a very intensive degree or if the owner does not particularly care for his possessions, the treasure can remain in its superficial hiding place and no attempts at burying it any deeper are necessary. If we apply this to certain neurotic symptoms,

and in particular to the rather superficial hysterical manifestations, one gets an explanation, why some demonstrative features of this kind can yield to any form of suggestive therapy very easily, while in other cases, the tenacity of the symptoms forms a strange contrast to their superficial localisation.

One criterium that appears to be essential in deciding, how far a conflict is to be buried and how far it can be announced by an open symptom, is the value which a particular culture or any group in it attaches to the idea of social and economic usefulness. The West is obsessed by the idea that the supreme aim of any human existence must be to turn out work that will not only economically support the person himself, but which will also contribute to the welfare of society. In India, perhaps again corresponding to the greater stress on inward life, which we find in classical writings, perhaps, however, also as a consequence of the climate which allows two yearly harvests, this idea of social usefulness, until recently, was of much less importance. It is, however, to be expected that the greater and more insistent demands, which the modern type of society is sure to place in increasing measure on each individual, may not only provoke more neurotic reactions, but also change their symptomatology.

One may say that, in children, the factor of economic usefulness does not play any role. We have, however, seen that most parents have quite particular expectations about the way in which their children should be or become useful to them, if not economically, then at any rate by fulfilling some ambition. In many cases, we shall see that the conflict arises between the child's need for individual development according to his own possibilities and his own optimal speed of realizing them and, on the other hand, the necessity to conform to the parents' wishes and to bend to the will of those on whom he has to depend for his livelihood and security. In other cases, the accents may be distributed differently. The threat may not consist in having one's emerging individuality suppressed by parental authority, but, on the contrary, in having to emerge into individual responsibility from an almost symbiotic existence sheltered in the well-regulated life of a joint family. Each case has its own peculiar features, and the figures and examples to be given in the following paragraphs will be more instructive than any further theoretical speculations can be.

(c) *Combinations.*

In all the groups of congenital and organic disorders which we have already presented, we have found children in whom the original trouble was complicated by what we called a neurotic "overlay" or "superstructure". Table 15 recapitulates the number of these combinations.

It is quite plausible that any illness or defect which impairs the organs and functions that serve for contact with the outside world, is likely to produce conflicts, as long as a certain sensitivity and capacity for discrimination are preserved. We have seen, in the oligophrenic group, that, amongst the most severe cases, no combinations with functional disorders are to be found.

TABLE 15

Combinations of Neurosis with Disorders of Congenital and Organic Type

Combination with :	Male	Female	Total
Oligophrenia	16*	3	19*
Postencephalitic States	5	4	9
Epilepsy	5	1	6
Other organic affections	1	—	1
		(plus 1 foreigner)	

*Of these, 2 cases each were at the same time combined with postencephalitic disturbances and epilepsy. These cases are not counted again in these other categories.

On the other hand, one now-a-days has started to suspect that some of the states which one used to regard as congenital mental deficiency, at least in its milder forms, may perhaps also be neurotic defences of a particularly tenacious and convincing nature. In some of our cases, we have seen that in children who realized that, by their intellectual weakness, they derive the benefit of being pampered, pretend to be more stupid than they actually are. As far as the postencephalitic group is concerned, we have already hinted that, more perhaps amongst the adults than the children, the readiness to catch an infectious illness and to develop cerebral complications, may not only be due to a same sensitivity that exposes to neurotic reactions, but may actually be increased by some acute emotional conflict.

Similarly, we have seen that a disposition to epileptic manifestations can be used in the service of neurotic symptom formation, while, on the other hand, worrying about fits, feelings of inferiority, being excluded from certain activities, can lead to neurotic elaborations, even if the epileptic manifestations themselves are of purely organic origin.

Above all, however, our study of these combined groups has demonstrated that intellectually or otherwise organically handicapped children are most liable to add some neurotic trouble to their basic disorder, if they are exposed in a unique position amongst their siblings or if, even without this, the parents' attitude fails to make the best of the child's limited capacities, either by excessive demands, unreasonable pampering, overanxiousness, inconsistency, neglect or open rejection. We have seen, in particular, that a child's handicap can often give an anxious and immature mother a convenient excuse for clinging to her child in her own interest, thus depriving him of his chances for growth, while all the time imagining herself to be a particularly fine model of devoted motherhood.

As in the 35 cases of combinations with the congenital and organic groups the neurotic symptoms are so closely connected with the original disorder and as, furthermore, we have already pointed out all the impressive features and illustrated them by examples, we shall limit ourselves, in this chapter on neurosis, to the 54 "pure" cases.

The term "pure" cannot be taken in an absolutely unqualified sense. We have mentioned earlier that some of the children classified in the functional group show evidence of some discrete organic damage to the central nervous system. Where such damage had not produced any obvious symptoms and, in particular, where its existence was not even known to the patient and his relatives, we have not treated it as a separate affection. One has, however, to take into account that children with such discrete impairments may be more sensitive to certain stimuli and less capable of reacting to them adequately.

In some cases, the neurotic symptoms were connected, either simultaneously or consecutively, with some acute illness that did not affect the nervous system in particular. Though a combination of this kind might possibly also represent a mere "functional overlay" of a physical disorder, no separate category has been established for these cases. We shall, however, give both, them and the children with discrete neurological symptoms, a special place in the paragraph on physical defects.

(d) Characteristics of our Material.

(1) *Distribution according to sex.* With 33 boys and 21 girls, *i.e.* a ratio of 1.57 boys to 1 girl, the neurotic group shows a much more even distribution than the congenital and organic groups, where we found an overall ratio of 2.8 : 1. It may be interesting to note that, amongst the cases of neurotic complication of congenital and organic troubles, the sex ratio, with 3.4 boys to 1 girl, corresponds much more closely to that for the basic disorders than to that for neurosis.

As the majority of girls, though also of boys, were brought at puberty-age, one may again wonder, whether perhaps the idea of making them fit for marriage was the motive that caused the parents to seek consultation. There are, however, quite a number of girls in our material, in whom neurotic symptoms were so severe, *e.g.* in the form of anxiety attacks or hysterical fits, that they themselves may have claimed help and that the parents, in their anxious concern and helplessness, had to resort to some suitable possibility for treatment. One may ask, as we have already done this earlier, though more in connection with the predominance of girls in the psychotic group, whether the critical phase of puberty and adolescence, with its biological and social stresses, may set in earlier in girls, and whether perhaps, at a slightly later age, at which the boys also have "caught up", the ratio may again shift more to the male side. As our case-histories of adults have not been worked through yet in this respect, we can give no figures. But one has to consider that, from puberty onward, girls and young women continue to be exposed to certain stressful situations at an earlier

age than boys and men have to face their main responsibilities in life. So, any such "shift" of puberty difficulties to a later age in boys, would hardly be recognizable from naked figures, as by that time the adolescent girls may already have advanced into a next phase of crisis, e.g. that of marriage, pregnancy, child birth.

(2) *Distribution according to age* (Graph I b).—As we have shown earlier, a pyramid based on the age at which children are brought for consultation, can give no true information about any age-factors that influence the onset of some trouble, but, at best, only about possible motives that may cause parents to seek help and advice at a particular moment. In previous groups, we have seen that the ages of school-entry and puberty with its prospects of marriage for girls and a career for boys, provide such occasions on which any handicap or behaviour difficulty is viewed more seriously than during phases when life continues in its usual routine.

The pyramid for neurosis also shows a certain accumulation at school-entry age, but a much more prominent jutting out for boys at the age of 10-11, which would be difficult to explain by particular considerations that recommend consultation at that time. The highest age classes, 14-16, present the expected broadening out of the pyramid for both sexes.

The graph does not convey much meaning, unless we can compare it with another one that represents the ages at which the first symptoms of a neurotic disturbance were noted. Our data may not be very exact ; but it is more likely that a symptom may have passed unnoticed for some time and that consequently the age of onset may have been given too late, than that the start of any trouble has been indicated at too early an age.

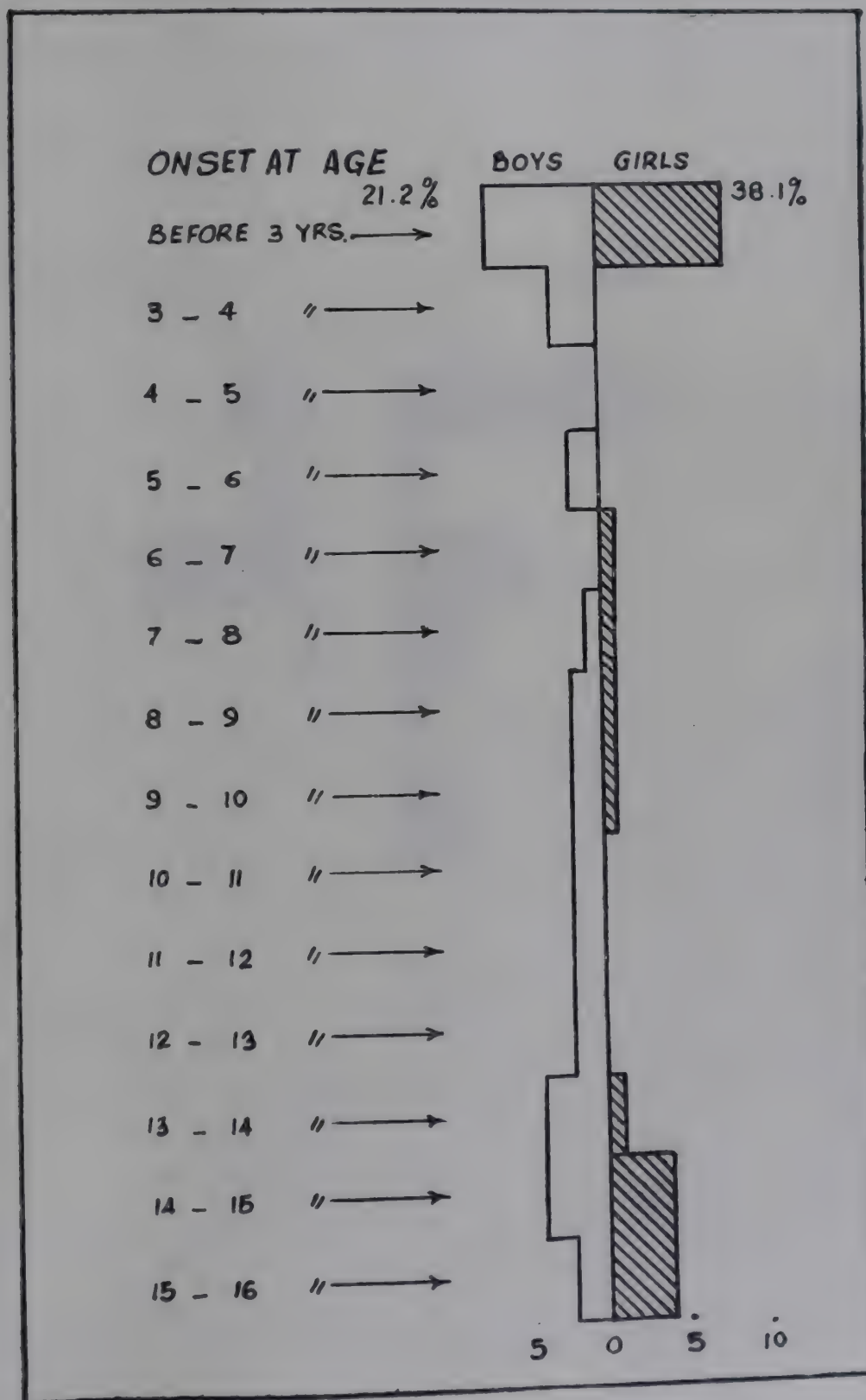
Graph I shows that quite a considerable number of children were reported to have been in some way "queer" or unbalanced right from infancy. In 21.2 per cent of the boys and 38.1 per cent of the girls, first signs of a neurotic deviation were observed before the age of 3 years.

From a further table (Table 16), indicating the duration of symptoms before the first consultation, we note that, in 15.1 per cent of the boys and 19.0 per cent of the girls, some trouble had been present for more than 10 years, before we got a chance of examining them. These can only be cases that were brought at puberty age, but had started some symptoms before the age of 3 or 4, as for any other age group, the interval of more than 10 years cannot be fitted in.

Unless, as we have seen it for congenital disorders, the parents only think consultation worth-while, when the child approaches maturity, one might take these figures as lending support to the Freudian theories, which place a first phase of active erotic interest, fraught with dangers of neurotic distortion, from early infancy up to about the age of 4 and, after a "latency period" of several years, a second one at the start of puberty.

Graph 1.

Onset of symptoms in neurotic children



Graph 2.

Main and Accessory symptoms in Neurosis

(Text see page 195)

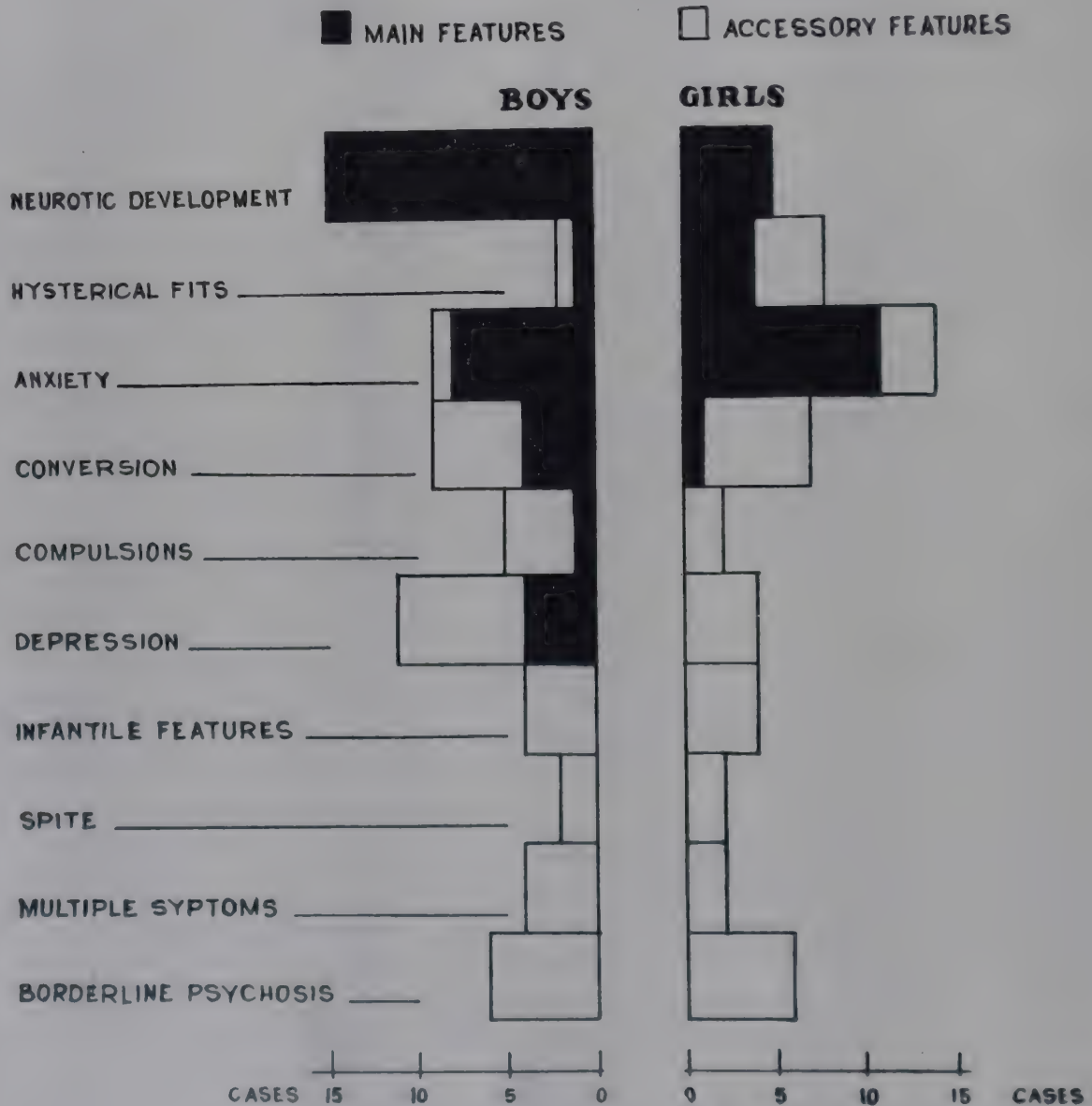


TABLE 16.

Duration of Symptoms before first Consultation
(Neurotic Group)

Duration of Symptoms before First Consultation	Male	Female	Total	
Several days	—	3	3	} 20 ; Boys : Girls 1 : 1
Several weeks (up to 2 months.)	5	1	6	
Several months (up to 1 year)	5	6	11	
1-2 years	3	—	3	} 25 ; Boys : Girls 2.5 : 1
2-3 years	3	2	5	
3-4 years	4	—	4	
4-5 years	3	—	3	
5-6 years	4	1	5	
6-7 years	1	1	2	
7-8 years	—	3	3	
More than 10 years	5	4	9	9 ; Boys : Girls 1.25 : 1
	15.1 %	19.0 %	16.6 %	

The cases that would not fit in with this theory, are the ones that showed the first symptoms of neurotic disturbance at the ages between 5 and 10, or to give a rather large margin in view of the earlier maturation here in India, let us say up to 9. One will see in Graph 1, that in 5 boys and 3 girls, onset of symptoms falls into this age span. We have taken the trouble to investigate, whether perhaps any particular causes may have been responsible for the origin of neurotic symptoms at an age so unorthodox according to Freudian views.

We find that, of the 2 boys who showed the first signs at the age of 5-6, one had been sent to a boarding-school, the other one had gone through a serious physical illness. The boy whose neurotic trouble dates back to the age of 7, was at that time upset by the birth of a younger sister and the departure of his parents to some foreign country. Of the two boys disturbed since the age of 8-9, one had a mentally ill father and a mother who had to start working outside the home at about that time, while the other one, an adopted child, rebelled against his foster-mother's lack of understanding. Of the 3 girls, for whom onset of symptoms was dated in what one would suppose to be the "phase of latency", one reacted to the birth of a younger sibling, another one, probably delicate and oversensitive since infancy, had an acute attack of anxiety, when left alone in a hospital where she witnessed the death of fellow-patients. In the third one, the parents' observations were probably not correct, as her trouble suggested a much earlier origin.

One herewith sees that Freudian theories could be justified by our material. We have, however, already earlier, mentioned that other authors, who put less stress on sexual development, place a first critical phase at the age of 3-4, the so-called "affective crisis", or the age of spitefulness, a second one at 7-8, the "age of reason", and a third one at pre-puberty, *i.e.* about 10-12. One easily could find support also for this theory in our material.

Once again we have to remind ourselves that the cases seen by us are only a small share of all children who are suffering from neurotic troubles and that we have no right to use this limited selection for proving or disproving any theories on the strength of mere figures.

All we can say without investigating individual histories, is that in a considerable number of cases, some disturbance had been noted since infancy and that some of these were only brought for consultation at the time of puberty, possibly because at this age parents were getting concerned about the future, or because already existing symptoms were exacerbated by the particular problems of that age. An even greater number of patients started their neurotic disorders at the age of puberty. The cases scattered between these 2 groups, as we have tried to do it for the few with onset of trouble between the ages of 5 and 9, probably will have to be examined each for its particular circumstances.

If we assume that, in this phase of cultural and social transition in India, emergence from a sheltered collective existence into individual responsibility represents the situation most likely to precipitate neurotic reactions, any experience which means exposure to a sudden realisation of one's individual, separate existence, no matter at what age, may mark the onset of symptoms.

The table listing the length of intervals between the start of symptoms and first consultation (Table 16) may rouse some curiosity about the cases that were so alarming that help was sought already a few days after the first appearance of disturbances. Two children, both small girls, were brought because of acute anxiety attacks, a third girl, of puberty age, because of tetanic fits with a strong hysterical component.

Amongst those in whom the symptoms had already been present for several weeks at the time of consultation, anxiety of an acute type again takes first place, while depression was the main sign in one boy, and a whole variety of symptoms, including anxiety and depression, in another. Anxiety is further prominent, in 6 out of 11 cases, amongst those children who were only brought after the trouble had lasted for a few months. In this group, we further find hysterical fits and one psychosomatic case.

It thus looks, as if the symptoms that are most likely to urge patient and relatives into seeking help, were those which acutely torture the patient himself (anxiety and depression) or which, by their dramatic nature, (hysterical fits) alarm the relatives.

More insidious neurotic developments, which perhaps manifest themselves more in a general distortion, some particular habit or behaviour disorder, or conversion into a physical symptom, seem to be less apt to move the relatives into speedy search for some remedy. In these cases, the moment for consultation is perhaps more likely to be determined by social factors or by the mere chance of having found an opportunity for expert help.

One has to consider that, for many of the young patients, we were not the first service to be consulted. Some of them had already made acquaintance with all possible systems of medicine and quackery before they were finally brought to us. What may surprise one, is therefore not so much that some parents only found the way to a psychiatric center (which had existed since 1950) after a disorder in their children had persisted for over 10 years, but rather that 37.0 per cent of all neurotic children were already seen by a psychiatrist within a year of the start of their trouble, 16.6 per cent even within 2 months !

(3) Reasons for Consultation and Main Symptoms.

In Table IV, the group of children with neurotic features was fitted into a scale which indicated the main reasons for consultation in the total material. We see from it that, by far the most important column, with 62.9 per cent, is that of "subjective symptoms", which in the organic-congenital groups had been left blank, as most of the children either had no subjective complaints or, if any were felt, were hardly able to formulate them. Next in frequency come behaviour problems, with 50 per cent, and intellectual disturbances, mainly in the form of lack of concentration, with 31.5 per cent of cases. In 9 of the 54 cases, delinquent features were noted, while a further 4 were marked as potentially delinquent. These cases, unless they present features which are very apt to illustrate any of the factors to be discussed in this chapter, will again figure in the separate chapter on delinquency. In the two cases noted in brackets, in the column for convulsions, epileptiform manifestations played no role at the time when the children were brought for consultation, but had only occurred sporadically in early infancy. They are only mentioned in this context so as to give a full survey of all cases that ever had presented epileptiform features.

One will realize that this rough classification, which may have served its purpose for the congenital and organic disorders, can hardly do justice to the finer differentiation and wider variation of symptoms in this neurotic group. We have therefore established a separate graph (Graph 2), which lists the most typical symptoms in greater detail. One will note that separate columns have been given for boys and girls and that, within these columns again, different shadings have been used. The more compact marking indicates those cases in which the particular feature indicated is the main or even exclusive one and which therefore can be used to characterize a particular type of neurosis, as *e.g.* hysterical neurosis, anxiety neurosis, conversion neurosis, compulsive neurosis, depressive neurosis. These same features, however, can be present

as a mere admixture in some other type of neurosis or as one of the varied, unsystematized symptoms in what we called "neurotic development". These accessory features have been given a less heavy marking. While the main symptoms will add up to the number of patients in the group (33 boys and 21 girls), the accessory features, as several of them can exist in one and the same case, while in other cases the picture of the illness is entirely characterized by one single feature, bears no relation to the total number of children. One will see that the cases which presented a great multiplicity of symptoms and those which we regarded as just touching the border of psychosis (listed either under "neurotic development" or the symptom that gave the predominant colouring to the condition) have also been added at the bottom of the list with the marking used for accessory symptoms. Other features which were only found in an accessory role, are spite and infantile behaviour. The latter, however, where it presented the dominant feature, has been classified separately in the group of infantilism. The same technique of presentation has been used in further graphs which, in later paragraphs, relate the main and accessory symptoms to other factors.

Graph 2 indicates that, with regard to the dominant features, neurotic development, *i.e.* a "building in" of neurotic features into general personality structure without any one characteristic symptom, is most frequent in boys, with anxiety taking second place, while amongst the girls this ratio is inverted : anxiety being far more frequent in its undisguised form than any other manifestation. The fact that, amongst girls, we have 4 times as many hysterical symptoms, for the main as well as the accessory features, than amongst boys, though the total number of girls is smaller than that of boys, confirms the age-old observation, from which even the term "hysteria" is derived, that hysterical features occur mainly in women. (The Greek "hystera" means "uterus", and the belief of the Greek physicians was that, in what nowadays we call "hysteria", the womb starts moving about in the body and causing various troubles.) In contrast to hysteria, which mainly utilizes for its expression physical functions accessible to conscious control, what we call "conversion", attempts a deeper and possibly also more permanent concealment of the conflict, with the help of some physical function outside the reach of consciousness. This category of "conversion", in which, amongst other features, we have classified stammering, shows a predominance of boys, where it is the main characterizing symptom, while, as an accessory feature, it occurs more frequently in girls. Depression and compulsion, perhaps the neurotic states in which "closedness", rigidity, lack of variability predominate most over openness, diffuseness and plasticity, have been registered as main symptoms only in boys, while in the form of accessory features, they also figure amongst the girls.

On the whole, this graph gives one the impression that the girls allow their symptoms to appear in less concealed and "congealed" manifestations than the boys, who seem to tend more to some kind of systematic fixation of symptoms. As we mentioned earlier, the proportion in which a symptom reveals and conceals the conflict, may partly depend on the time that has been available for elaborating any symptom.

Going back to Table 16, we note that the shortest intervals, of a few days only, between first disturbances and consultation, all are on the girls' side, while duration of symptoms of a few weeks is five times as frequent in boys than in girls. For all intervals up to one year together, the absolute figures, with 10 boys to 10 girls, are equal, which, relatively, signifies a slight predominance of girls. The longest intervals, amounting to more than 10 years, characterizing a very gradual development, are slightly more frequent in boys, as far as absolute values are concerned ; but relatively, the figures of 15.1 per cent for boys and 19.1 per cent for girls, again indicate a majority of girls. We have, therefore, no reason to suppose that the prevalence of a more diffusely and superficially arranged symptomatology amongst girls is the mere result of a time factor. If, furthermore, we take into account that "borderline" cases still counted in the neurotic group and also full-blown psychotic cases are definitely more frequent in girls than in boys, these observations will confirm the fundamental truth that female human beings, not only in their physical structure, designed to receive and to bear, but also in their whole being, are more open and variable than men who, for their function of standing up and penetrating, have to assume a firm and well-limited structure. While, probably, one would find this same proportion of openness and variability on one hand and firmer structure on the other also amongst western women and men respectively, the level of openness, round which this difference between the sexes would balance, would certainly be shifted towards the side of closedness and firmer structure in the West.

Open expression of an all pervading anxiety, without any attempt at crystallizing and limiting it to a well-defined "phobia", and such superficial neurotic arrangements as hysterical manifestations, have become rare in the West. On the other hand, such seemingly compact symptom formation as we find it in compulsions and obsessions, also seems to have become somewhat outmoded in the West, while here in India, probably in connection with orthodox customs, they still present a ready-made opportunity for investing neurotic conflicts. Where, as in compulsive syndromes, firmness has turned into "anorganic" rigidity, one always has to suspect that it conceals a helpless lack of boundary which, following the lifeless principle of "all-or-nothing", has been converted into its opposite. In general, one would certainly be justified in maintaining that the Western patient tends to conceal his conflict more deeply than the Indian one, while amongst both, Western and Eastern neurotics, the men again show more tendencies to limit and crystallize their trouble in firm and deep-seated structures. We shall of course have to see, whether the distribution of neurotic symptoms amongst our adult patients equally justifies this assumption ; amongst the children, one certainly would find support for it.

We shall have to come back to the distribution of main and accessory symptoms in presenting some of the characteristics of our group. For the present purpose of introducing the various possibilities met with in our material, presentation of typical individual examples may be more instructive than any further general reflections.

The symptoms which figured as main features will be illustrated by cases in which they provided the predominant note ; cases in which certain features were only "accessory", will only be given as examples for those symptoms that were not counted as principal ones.

- (66) *Sohan's* history, for instance, might just as profitably be given as an instance of an only child. He is, however, typical for this group, in so far as most of the cases of "neurotic development" seemed to be the result of excessive parental ambition. (See Graph 5).

His father, a jovial and somewhat boastful Hindu business-man, at times went into severe fits of anger, but, on the whole, had been only too lenient with the boy. The mother, aged 24, when the boy was born, was very busy in her social life, taking great pride in entertaining guests. She admitted quite openly that both she and her husband had never wanted more than this one child. From the beginning of their marriage, they were very careful in applying contraceptives, not only to time this one pregnancy several years after marriage, but also to prevent any further issue. Consequently, all their hopes and ambitions were fixed on this one boy. The mother resented that, due to her early marriage, she had missed the chance of higher education, and was obviously trying to realize through her son, what she could not achieve in her own youth.

The child was expected to stand first in his class, to study all the time, to be a well-dressed, sleek-mannered drawing-room boy, in short : to be perfect in every respect.

He had, however, started his life with the severe handicap of a premature delivery during the 7th month, after a pregnancy disturbed by kidney trouble and high blood pressure in the mother. Discrete neurological symptoms, when we examined him at the age of 10, betrayed that these complications of pregnancy and delivery had left their mark on the central nervous system. He was only breastfed for 4 months and already at the age of 2, as soon as he could walk and talk, pushed out from the secure maternal nest into nursery-school. At 5, he was sent to an English convent-school as a day-scholar and at $7\frac{1}{2}$, at a time when he had not even learned to tie his own shoe-laces, to a boarding-school with rather strict discipline, far away from home. His delicate health and sensitivity seem to have been further accentuated by infantile liver trouble. He also suffered from frequent tonsillitis, various fevers and a fall with fracture of the left hand. From early childhood, he had been very soft-hearted. He could not bear to see anyone suffering, even on the screen of the cinema.

While the contrast between the material pampering which the father in particular lavished on him as the "son of a rich man", and, on the other hand, the lack of understanding for his emotional needs and the high demands on his scholastic

achievements and perfection in manners, no doubt had already insidiously forced him into neurotic defences early in childhood, the "symptom" which finally alarmed the parents, was his failure in 5th class at the age of 10, and his promotion with poor marks the year after. At the same time they complained of his restlessness, his lack of concentration, his playfulness and his carelessness in matters of order and cleanliness.

During the few occasions we had for examining the boy, one at the age of 10 and then again 3 times at the age of 11, he impressed us as quite bright and intelligent. In particular, he displayed an amazingly expert knowledge about any matter concerning cricket. He also showed some interest in crafts and planned to become an engineer. He realized perfectly well that acquiring knowledge was essential, not only for this professional aim, but also for gaining independence from his parents. But, as he resented their excessive demands and ambitions, which by any success in scholastic life seemed to be stimulated into soaring even higher, he, partly consciously, partly unconsciously held back his capacities. While, with his parents, any little sign of appreciation and affection had to be earned very hard by persistent studying, he found that he could gain his fellow-pupils' sympathy and admiration very easily, not only by being an expert in games and stamp collecting but by boasting about his father's enormous wealth and by freely distributing his own portion of it to gain favours. On one hand he was exhorted, particularly by his ambitious mother, to gain his place in the world by industrious, disciplined and honest effort, on the other hand, his father impressed on him quite early that, being the only son of a rich man, he would be able to attain anything he wanted in this world by the power of money. For a long time, we very much hesitated in deciding, who of the two parents had exercised a more harmful influence on the boy's development : the father with his tendencies towards fulfilling any material wish and giving him the means for generosity without any own effort, or the mother with her rather harsh attitude of pushing the sensitive child out into a demanding world too early. A sign of this dilemma between lenience and harshness, was perhaps that, in his English spelling, the boy had a quite selective difficulty in distinguishing "hard" consonants, like "k, t, p", from the softer ones like "g, d, b". In the boy's responses to projection tests (Thematic Apperception Test), the mother seemed to be the frightening figure, compelling him to efforts going beyond his strength. She appeared to represent his own conscience, which was trying to stand up against his tendency to take the easy way, to gain recognition, not by hard effort, but, following the pattern of his boastful father, by throwing about his money and even by inventing phantastic stories.

The self-portrait which this boy drew at the age of 11, seemed to sum up his situation admirably : a figure dressed like an adult, in long pants and hat, but with his arms extended in an utterly helpless gesture and eyes gaping wide with

anxiety. One could, in fact, underneath all the superficially lively and restless behaviour, sense a note of deep sadness and tiredness. One sees that, in this case, not only a sensitivity and immaturity of the nervous system after premature delivery, but also harmful environmental influences had been acting steadily right from birth. The boy's defences were not so much built up in the form of well defined symptoms, but rather integrated in his whole development and mode of reaction to the "outside" world. What finally alarmed the parents, was not so much this development in itself, but the outward effect it had in frustrating their ambitions for the boy's scholastic attainments.

As hysterical manifestations are more frequent amongst female patients, we choose one of the girls as an example :

- (67) *Amrit Kaur*, aged 15, was the 4th of 6 children of a Sikh refugee family from Pakistan. The father, a shopkeeper, flared up in anger rather easily. The mother, already grey-haired, seemed to be more intent on talking about her own aches and pains than on providing information about her daughter.

3 sisters, 2 elder and one younger, and 2 brothers, one elder, one the youngest and mother's favourite, were all healthy. They lived in joint family with some other relatives.

Amrit Kaur had always been "sticking out" from amongst her siblings through her exceptional tallness, which exposed her to much teasing. This physical peculiarity, which at the time of puberty seemed to assume proportions reminiscent of acromegalia, a sign of pituitary disturbance, was all the more awkward, as in her intellectual and emotional development, the girl could not live up to the expectations which her tall growth automatically provoked in anyone who saw her. Always a very moderate student, she had failed in 6th class at the age of 13. Though she managed to pass the next year, she gave up further studies. This failure, which had brought her in some more teasing, occurred at about the same time as the eldest sister got married. When the bride went to join her in-laws, the usual household chores were of course shifted down to the younger girls, and Amrit Kaur had to face increased responsibilities, particularly after she ceased going to school. Menstruation had started approximately at the age of 12, but did not follow a regular course.

To the critical situation of failure in school and increase in her share of housework through her sister's marriage, at a time when the probably always precarious hormonal balance was taxed by the biological changes of puberty, Amrit Kaur had reacted by going into sudden fits of shouting, abusing and wild gesticulating with hands and feet. At other times, her body would get stiff in such fits or, without any particular motor manifestations, she would simply shout abuses at anyone who came near her. At the same time, she lost sleep and appetite and complained

about heaviness in head and stomach. The girl herself, tall, long limbed, with nails bitten and thyroid slightly prominent, complained of stiffness, pain and tingling in her limbs, palpitations and a sensation of "choking" in her throat. One was struck by the obvious contrast between her tall figure and her childish behaviour.

During the second of the 2 interviews, she sat with head bent, eyes closed, looking blank and sad. When asked about any particular trouble, she replied that, in this particular state, she felt that she could beat anyone. After a while, quite elegantly, so as to avoid any injury to herself, she let herself fall from her seat on the "takhat" on to the floor and remained lying there in an apparently unconscious state. The pulse remained vigorous, respiration calm, and the complexion showed no change.

While the family's description had still left some doubts, whether the fits might not perhaps be of epileptiform nature, this demonstration made it quite clear that no organic factor was involved. According to her parents, such fits were most likely to occur, when anyone criticized or scolded her. The fit, on one hand, seemed to represent a manoeuvre for shutting off any conscious outburst of anger, while, on the other hand, it allowed quite expressive demonstrations for which, in an "unconscious state", she did not have to feel responsible.

Suitable medication reduced the incidence of fits. But the 2 interviews gave us no opportunity for influencing the girl herself and her parents at a more fundamental level.

Anxiety was found in its purest, "free-floating" form, —or rather formlessness ! —in some very acute reactions, but could also persist as an all-pervading element of longer duration.

One of the most remarkable acute cases, remarkable not only in view of its occurrence at an early age, but also because someone had the good sense to recognize its nature and to seek advice and help, is that of the youngest patient in this group, a little orphan girl aged $2\frac{1}{2}$:

- (68) *Caroline* had been brought as a foundling child of unknown origin to a Roman Catholic orphanage at the age of a few days. Her mother was supposed to have died at birth. Under the motherly care of the nuns and novices, she developed into a very bright, lively and intelligent little girl. During the few weeks preceding the acute anxiety attack, she had started becoming inquisitive and exploring the world further afield. The nun who accompanied her to our Center, admitted that, in their pride and joy about this favourable development, the staff members possibly had encouraged and pushed her a bit too much in these attempts at emancipation.

A few days before we had occasion to examine the little girl, she had been playing in the garden with the other children of the orphanage. When the station-wagon, after being washed, was to be taken back to the garage, the young novice who was supervising the children and who was of lively Italian temperament, suddenly had the impulsive idea of giving the children a ride. She quickly put some of the small toddlers into the open back of the car. Amongst the last to be lifted onto the vehicle, was our patient and a very weak, sickly little boy, who had only learned to walk on his rickety legs quite recently. While most of the children seemed a bit scared by the sudden manoeuvre, this little boy gave free expression to his anxiety by breaking into loud weeping. Immediately, little Caroline also began to cry and to shout the little boy's name in an anxious tone. After this event, she kept showing unusual concern for her little play-fellow, repeating his name again and again, and quite generally presenting unmistakable signs of anxiety. This was all the material reported to us. As the child was too small for any systematic exploration, we had to rely on intuitive guesses rather than on any conclusions developed from thorough observation. One such guess, which probably would have been uppermost in the mind of any true "Freudian", was that, in her recent exploring mood, the girl might have investigated the little boy's genitals and that some "guilt" feelings about such illicit curiosity might have been at the bottom of her anxiety. The Italian nuns, who showed remarkable openness and understanding for even so "shocking" a possibility, though not knowing of any particular incident of this kind, admitted the theoretical possibility of it. In order to test the child's reaction, we presented to her two small plasticine figures, in whom the male and female sex attributes had been modelled with some exaggeration. The girl showed no sign of particular concern.

The next assumption, still on a rather Freudian level, was that the sudden moving away from the young novice, the mother-figure, had recalled and reinforced "memories" of the initial "birth-trauma", which for some authors is the *primaeval* pattern for any later anxiety. In order to see, how far this hypothesis might apply, we made the child play with a small toy train and some bricks. In the course of play, we put the 2 small clay figures onto one of the railway carts and moved it away from a house built with bricks. At that moment, the child froze into a motionless position and showed some signs of tension. Later, she wanted to hoard all the toys in her skirt and to take them away with her.

All we could say was that the anxiety, provoked by the sudden moving away from the mother-figure, seemed to express some general insecurity. No doubt, the child may have been sensitized to such "separation anxiety", not so much perhaps by the act of birth itself, but through her losing her mother and being exposed as a foundling so soon after birth. The question, however, remained, why then, in her anxiety, she had not been driven into worrying about her own existence, but about the safety of the little play-fellow. We ventured the interpretation

that the sickly, weak little boy, towards whom her anxious concern was directed, may have symbolically represented the weak and helpless part within herself, which, in her recent phase of emancipation, had been left too far behind.

Apart from prescribing light sedation for a few nights, we advised the nuns to refrain from pushing the girl too much in any of her inquisitive and enterprising tendencies and, instead, to "baby" her a little, to sit beside her bed in the evening and, at the same time, to show her that the weak little boy also got all the mothering he needed.

One may wonder, whether an early phase of anxiety of this kind may possibly leave its trace on a child's development. One certainly has no right to maintain that a first experience creates a kind of groove or even already follows in a groove traced by the *primaeval* "birth anxiety", and that all later anxiety, even up to adult life, is nothing but a secondary replica of this primary model. Every situation of anxiety, whenever it may occur in human life, deserves to be taken in its very own immediateness and uniqueness. What may be in common to all such phenomena, however, may be a sudden experience of being exposed in one's individual limitation. Losing the shelter which a continuous transition of need into automatic fulfilment provides, and which may allow one to persist in an illusion of unlimited merging, similar to the life of the embryo in the mother's womb, seems to be the one experience that is most likely to provoke deep anxiety. The emergence from the womb may be one example of this fundamental situation, but it certainly cannot be called the basic situation of which any further anxiety is simply a repetition. (On this interpretation of primary birth anxiety, see also Boss (23).)

In practically all our patients, children and adults, vague anxiety and its slightly more crystallized versions of "fear of being alone", "fear of darkness", "fear of death", far from being an expression of sexual guilt, as enthusiastic Freudians might maintain, seemed to be stirred up by situations that made them realize their individual separateness and the limitations of their existence, in other words : the loss of shelter and closeness. (The two terms "shelter" and "closeness" only succeed to a very limited extent in conveying the meaning of the German term "*Geborgenheit*", which gives "shelter" the meaning not just of a roof and 4 walls, but of a kind of loving embrace that hides one from all dangers, excessive demands and frustration. This meaning, in German, is quite immediate, as one easily recognizes in "*geborgen*" the same root as in "*verbergen*", *i.e.* to conceal and "*entbergen*", to reveal.) The emergence into this separate existence can be a process of harmonious growth and maturing, if it is supported by the uniting forces of love and of faith in some eternal foundation, which still provides shelter even when all worldly protection fails. If lack or a wrong type of parental care has not encouraged such faith and love, and if some outward situation of shock and insecurity opens the prospects of this individual existence too abruptly and too early, before the readiness for it has grown, the result

can be acute anxiety. Possibly, the experience can be covered up again, but it may leave a permanent sense of insecurity. This again, as any definite symptom is more easily born than a vague, all pervading discomfort, may be tied down or crystallized in a particular symptom or set of symptoms.

While a certain sensitivity and shaking outward experiences can lead to such irruption of anxiety at practically any time of life, one will naturally expect that the period of puberty, with its awakening of individual consciousness and conscience, is a particularly apt time for their occurrence. Anxiety, in fact, plays quite an essential role in many of our neurotic adolescents, sometimes in quite open form, sometimes in a more or less obvious disguise.

- (69) The history of *Uma Shankar*, a Hindu boy of 14, may serve as an example of an anxiety-ridden adolescent :

On recommendation by one of our former patients, he was brought by his father, a farmer, from a small town in UP. The boy was the first child of his parents, and his mother had breastfed him up to the age of 3. He started walking and talking at the age of 1 year and was a quiet and content child. When he was aged 6, his mother died. His paternal aunt, a widow, then took care of him. Later, the father got married to a sister of his first wife. While from his real mother, *Uma Shankar* only had one younger sister, 3 step siblings, but only 2 of them surviving, were born from this second union. At the age of 9, the boy left the secure nest of the joint family for a boarding school. Always obedient, calm and not inclined to quarrel and anger, he remained the favourite child in the family.

At the age of 12, however, he began to complain of palpitations and nervousness, of headaches and at times some jerky sensations in hands and feet. Sometimes, he would suddenly get upset, appear angry and talk irrelevantly or refuse to eat. When he was brought, 2 years after these symptoms had started, he described the anxiety attacks as follows : He would feel some heat and reeling sensation in his head, pain in his body and darkness before the eyes. At the same time, he would vaguely experience some fear of failing in an exam. but also some anger. He would then become quiet and weep, but remain so irritable that he could hardly bear to hear anyone talking. After such attacks, his body would get all limp and loose, and he would feel like cracking his knuckles.

In this case, the physical signs of anxiety, as transmitted and shaped by the vegetative nervous system, already seem to have superseded to a certain extent the elementary experience of anxiety. The concern about exams also shows that this boy is already about to channelize an originally presumably vague and free-floating anxiety into some so-called "conversion [symptom]" of physical type or into a phobia, *i.e.* an obsessive fear limited to one particular situation as its fixed object.

We know of no acutely precipitating circumstances in this case. Loss of the mother at the age of 6 and separation from the joint family at 9 may have shaken confidence and brought first experiences of separateness. The appearance of symptoms at the age of 12, seems to announce the process of individual emancipation which is characteristic for puberty. One may, however, wonder, whether this boy, who had spent his childhood in the secure old pattern of the joint family in a rural setting, may have been particularly unprepared for this realisation of separateness, which education in a modern setting may have forced on him prematurely.

Further examples of anxiety reactions and of more permanent anxiety states will be given in other connections.

While already in this last case one could note beginnings of "conversion", *i.e.* of a channelizing of the original unqualified experience of anxiety into its physical manifestations, a number of cases presented more distinct symptoms of such conversion, either as the main feature or accessory traits. One of the most persistent and well-characterized forms of such "conversion", starting at a very early age, is stammering. Amongst our children, we have 3 stammerers, rather characteristically all boys and all first-born. The eldest amongst them is Promod, already approaching the age of 16.

(70) *Promod* had come to our Center on recommendation by a psychologist in his city. According to the accompanying mother, the speech disturbance had first been noted at the age of 3.

Promod's father, an engineer, Kshatrya, was described as generous and sociable, but irritable and hot-tempered. The mother, a graduate, of rather fat, bulky physical type, suffered from asthma. She seemed to be overanxious with regard to the boy and almost compulsively particular about order and cleanliness. During the first pregnancy, she was worried and anxious to please her in-laws. Delivery of this first child, at the time when the mother was aged 24, the father already 34, was complicated and prolonged. A swelling on the scalp was visible for more than a month. The boy was breastfed for 2 years, practically until the next child, a girl, was born. A second sister was 5 years younger than the patient.

At the age of 4, Promod, who was an obedient, but somewhat anxious child, was taken to Lahore by his grandfather. He felt homesick and had to be sent back to his parents before the planned stay was over.

Already before that, at the age of 3, the speech disturbance had started. On his own insistence, the intelligent little boy was already sent to school at the age of 3. Children of different standards were taught in the same class room. Though Promod was the youngest and smallest amongst all these pupils of different ages, he was very ambitious. He himself felt that his intellectual eagerness went beyond the motor means of expression he had developed at that time. Stammer-

ing at that age occurs in quite a number of children, particularly the intellectually bright and lively ones, but remains a temporary feature, indicating a disparity between intellectual and physical, in particular motor, development, until after some time the latter catches up. In Promod too, in spite of the experience of separation from his parents mentioned above, the speech disorder subsided at the age of 5-6.

At the age of $8\frac{1}{2}$, however, he had a severe attack of typhoid, which kept him in bed for 5 months. After this prolonged illness, which probably had weakened his physical energies, while his intellectual brightness was not affected, the stammering again appeared. He remained a first-class pupil with good all-round interests and, when he was approaching the age of 16, he had already passed his Intermediate exam in Science.

Tall and sturdily built, with the physical signs of maturity fully developed, he was usually taken for 1-2 years older than his actual age. The boy had observed himself very well and was able to give us the following information about his trouble : His speech is unimpeded, when he sings or recites alone, or when he talks to servants, children or other people who are his inferiors. The stammering gets worse, when he has to face some strangers, when he is in an excited mood or when he is recovering from some fever. He has noted that the thing that makes him most angry, is other people's stupidity. He often can only see their point of view after having flared up in anger. He realizes that he thinks faster than his motor functions of speech can follow ; in his mind he is always "ahead". During sleep, he at times suffers from nightmares.

According to his mother, Promod was somewhat withdrawn, as he feared the teasing of his friends. At times he was moody and bad-tempered. He wanted love and affection, but in his self-willedness, resented any interference.

The history of this young stammerer is fairly typical with regard to some of the features, as *e.g.* his being an eldest son of an irritable father and an overanxious mother, the early intellectual ambitions, the reinforcement of early symptoms through a severe illness, the factors that reduce or intensify the stammering. In one single interview, we were not able to find out more details about early infancy, and we therefore do not know, whether particulars about weaning, toilet training and shocking experiences with regard to early sex-play etc., might have confirmed some of the characteristics indicated in psychoanalytical literature.

One can find quite phantastic theories, operating with such terms as "oral frustration", "displacement" of conflicts about excretory functions to the "upper pole" and others more. What is perhaps the most striking feature, is that stammerers usually seem to be in a hurry to reach some high, ambitious aim, while the physical functions cannot quite follow in this high flight of ideas. One of the adult stammerers treated at our Center, for instance, subjected himself to exercises, hormone injections and

all sorts of other practices in the hope of adding half an inch to his delicate stature, so that he might become a smart officer in the Army !

Physiologically, a vicious circle of anxiety, cramped up breathing, difficulty in phonation, being shocked about hearing one's own defective speech and increased anxiety about having to expose oneself with this embarrassing handicap, seems to be involved. Consequently, treatment can attack the trouble on three different levels : The most superficial method is that of speech training by practicing the correct phonetic positions and processes, reading aloud, reciting etc. Breathing exercises can cut the vicious circle at the second stage. One often finds that, instead of speaking during the phase of expiration, when respiratory and phonetic functions go in the same direction, the stammerer spasmodically tries to utter some sound, in particular the explosive consonants, while at the same time inspiring. This naturally creates antagonistic currents. One gets the impression that this ill-placed drawing in of air, at a time when expiration should supply an outgoing air-current, is in the service of physical "inflation". This may be symbolic for an attempt to make oneself swell to a size which will impress the dreaded partner in conversation or a wider public before which one is exposed.

A third method of treatment tries to attack the evil at the root, where the anxiety is seated. Such therapeutic attempts, however, usually are long-range procedures, and the customary hurry of the stammerer often makes him lose patience before any significant result can be gained. The more superficial methods may have their value as adjuvants and in cases of recent onset, or where the symptom has remained a "frozen" habit, long after the initial anxiety has been overcome.

The small percentage of stammerers in our material (as a main diagnosis only in 5.5 per cent of all neurotic children), probably stands in no proportion to the actual incidence of this trouble. It looks, as if many parents either got used or reconciled to the child's trouble. Amongst our adult patients, we have quite a few, in particular young male students, who came for treatment as soon as they could do so on their own initiative, while the parents had never bothered to do anything about the awkward symptom. The recent official instruction that stammering is not to be considered as an obstacle to fitness for Government service, certainly indicates that the problem is one that has to be reckoned with far beyond the scope of a psychiatric clinic.

Conversion symptoms as minor, accessory features, have already been demonstrated in their initial stage in the case of Uma Shankar (69) and will be found occasionally in further cases to be quoted later.

While compulsive features figured to some extent in at least 6 cases, they formed the main element only in one case, which almost borders on psychosis :

- (71) *Iqbal*, a Muslim boy, student of 10th class, came for consultation on recommendation of the family doctor, when he had almost completed his 16th year.

The onset of neurotic symptoms, however, was dated at the age of 10. The boy had grown up in a joint family, which presented a whole collection of nervous disorders : One paternal aunt was described as mentally deficient. The father, a businessman in a town of U.P., seemed to be a rather excentric man. He had suffered many losses in business and was deeply disappointed about his useless sons. According to himself, he had suffered from "heart-trouble" ever since, at the age of 10, someone had tried to strangle him. It is very likely that this "heart-trouble" was a neurotic conversion symptom. Iqbal's mother, a short-tempered, uneducated woman, invested all her interests and energies in compulsive cleaning and washing. On one hand, she pampered her children, on the other hand she would avoid contact, when they were dirty or sick.

Of 9 children in this family, 3 had died. The eldest surviving one, aged 28, was a bad-tempered, aggressive loafer. Only shortly before Iqbal was brought for consultation, he had taken up some pedlar's job, so that he could provide for his wife and 2 children. A next brother, aged 26, was mentally ill and had to spend part of the time in mental hospitals. A third brother, apparently particularly pampered by the mother, had had no education. He just wiled away his time with loose women, careless about his own wife. A further brother, aged 20, had failed 3 times in his High School exam and had not attempted any work yet. Next to him comes our patient and, 2 years younger, one more brother.

Obviously, the boy had had no inspiring example of masculine strength and firmness in the family. Whereas, in his elder brothers, laziness, lethargy and vice seemed to be completely dominant, he himself seemed to be torn by two forces : a wish for ease and comfort, but at the same time a certain ambition to do well in life and to be regarded as virtuous.

After a normal delivery, he was breastfed for $1\frac{1}{2}$ years. He was quiet and withdrawn and only mastered the functions of walking and talking at the age of 2. He was sent to school at the age of 5 and, contrary to his elder brothers, proved to be interested and clever in learning. At the age of 15, he had reached 10th class. He would have liked to continue his studies, if by that time, his symptoms had not grown to an intensity which no longer allowed him to devote any energy to school-work.

Already as a small child, Iqbal had shown unusual interest in religious practices. At the age of 10, he kept one month's fast at Ramadan. After this, his health declined ; he lost interest in everything and developed some compulsive habits. This timing of the onset of symptoms after the period of fasting may have been a rationalisation by the parents ; it is, however, quite possible that a certain state of exhaustion may have brought out latent tendencies more clearly. In quite a number of our adult compulsive patients, some infectious illness or exhaustion through nursing other family-members during some severe disease, had either

provoked the symptoms or exacerbated those that had already developed earlier. No doubt, the boy had had a drastic example of compulsive symptomatology in his mother, and the first compulsive habits may have started long before this fasting, which in itself, at that early age, was already a sign of compulsive inclinations.

By the time we examined the boy, almost 6 years after the start of his trouble, he had increased the time for his daily ceremonial washing and bathing up to 4 hours. He got into violent quarrels with his brothers about the use of the bathroom. The parents reported that he had become so particular about the purity of his food, that he would only eat standing, probably so as to keep the region of his excretory organs further away from food and mouth than this would have been possible in a sitting or squatting position. He was also noted to spit frequently, as if he had to relieve himself of something dirty. His powers of memory and concentration had slackened, and he could often be found lost in deep thought. At times he would suddenly pinch his mother. The parents suspected him of masturbation ; which apparently had been a quite frequent and open practice with his useless elder brothers. Iqbal, however, violently protested against this allegation, as he considered anything of that kind as a great sin.

On examination, the fairly well built and physically mature adolescent, dressed in spotless white pyjamas, kurta and cap, appeared tense, defiant and depressed. His jaw muscles in particular seemed to keep a firm lock on his mouth, which was only broken every now and then by disgusted spitting. Instead of answering any of our questions, he insistently lifted up his shirt and pointed to the region below his ribs on the right, digging, with expert fingers, again and again into the one spot which he indicated as painful. We could not quite exclude some trouble of liver or gall-bladder and advised further physical examination. Possibly, however, he may simply have meant,—as we have often observed it in little educated people, that his “*kaleja*”, *i.e.* the organ for courage, for confident facing and digesting of the world, had become deficient. He complained of weakness, depression and lack of control over his mind.

After we had satisfied his demand for physical examination, we were able to discuss his situation. He admitted that he was in a dilemma : on one hand he was disgusted with his useless brothers, and he abhorred the thought that he should become idle and careless as they were ; on the other hand, he resented that anything he might attain and earn by pursuing his own education or by engaging in some work, would ultimately have to contribute to feeding these loathsome parasites. His illness seemed to solve the situation by compromise : neither could he be accused of being a loafer ; nor did he have to engage in any labour or even preparation for work, of which the fruit would have been snatched away by the idle brothers. This interpretation, of which the boy seemed to be fairly conscious, remains of course on a very external level. The unscrupulous loafer was not only a figure which he saw incorporated in the brothers, but it threatened

him from within. By his constant spitting, by his preoccupation about his cleanliness, he demonstrated drastically, how little he really felt pure and perfect. The puzzling mixture of repulsion and attraction with regard to "dirt", which often characterizes such cases, was betrayed by a typical gesture :

While, for a few minutes, the boy had to wait in the doctor's office, which certainly must have come up to all his ideas of outward order and cleanliness, he spat a good-sized blob of saliva and mucus on the clean cotton cover of the "takhat" padding. When, on entering the room, the doctor viewed this unexpected defilement with some surprise, he very quickly sat down on it and pretended, though with a very guilty countenance, that nothing had happened.

As the boy seemed very severely disturbed, close to a psychotic breakdown, and as the home atmosphere certainly was not conducive to any relaxation, we advised hospitalisation in our in-patients' department. The father took some time to reflect and, after a few days, came to announce his decision of taking the boy with him on a business trip to Pakistan.

A state of depression, which perhaps might deserve the name of "exhaustive depression" rather than of "neurotic depression", was the main feature in the following case :

- (72) *Jagdish*, aged 15, was referred to us by a general practitioner, whom he had consulted for pain and heaviness in his head, pain in the legs, disinclination to work and general depression. His father, a farmer of scheduled caste, from the outskirts of Lucknow, had died, when the boy was aged 9. An unmarried uncle gave some help in managing the farm, but the main load seemed to have fallen on Jagdish. His one brother, 2 years older, mentally dull and careless, had gone to earn his living as a labourer in the city. Two sisters, one elder, one younger, were married. Jagdish himself also was married ; but his wife had not joined him yet.

So, from an early age, the boy was not only deprived of any formal education, but burdened with heavy work and responsibilities. One year before we saw him, he had had some febrile illness. Since then, he had never properly recovered. It seemed, as if the premature facing of adult activities and preoccupations had exhausted his undeveloped energies, so that only the addition of a minor physical trouble was needed to overthrow the precarious equilibrium completely.

As, on stool examination, we found eggs of hookworm and round-worm, it seemed plausible that this parasitic infestation had also contributed to exhaust his strength. Even after he had been successfully treated for this trouble, however, he took a long time to recover from his depressive lack of interest, showing tendencies to invent new imaginary physical symptoms, which presumably had to serve as an excuse from facing his difficult situation. The overanxiousness of the mother who

thought that, after this illness, the boy should be spared any effort, frustrated our attempts at building up his self-confidence again by gradually taking up some work.

While, in this case, depression seemed to be more due to an actual depletion of energies, favoured by physical trouble, it can, in other cases, cover up a deadlock between powerful aggressive urges and an equally strong conscious control that tries to keep them down, a situation quite similar to that we have observed in the previous case, the example for compulsion (Iqbal, 71). One finds, in fact, that compulsive symptoms and phases of depression can occur alternatively or at times even simultaneously, in the same patient. We may have occasion to present examples of such alternative or simultaneous solutions later. In Jagdish's case, the alternative to depression seems to have been investment in hypochondriac symptoms, once the actual cause for physical complaints had been removed by the treatment against intestinal parasites.

The cases in which a general uniform retardation of physical, mental and emotional development simply made the child appear a few years younger than the actual age, have been classed in a separate group, that of "infantilism". Some children showed a combination of infantile features with other symptoms. Some of them may originally have been plain cases of infantilism, but may, under pressure of their environment, have lost the relative harmony of a uniform retardation. Others again may have retained infantile traits or perhaps have regressed to them in some particular sphere only, as part of a more complicated defensive structure. The playfulness and lack of responsibility, about which Sohan's (66) parents complained, might possibly count as infantile features of this latter type.

- (73) *Tajwar*, son of a Muslim cousin-marriage, can serve as an example of the first alternative. Furthermore, his "childishness" is perhaps not so extraordinary in itself, but only assumes "pathological proportions" when measured against his parents' undue ambitions.

The father, a sensitive intellectual, was suffering from various psychosomatic complaints. He was loving to his children, but rather reserved and apparently expecting them to behave like little adults. The mother, a delicate woman, suffered from frequent migraine-attacks (also a psychosomatic affection!). According to her husband, she resented giving time and care to her children and often got furious with anger, when they claimed her attention. After several abortions at the start of married life, great care was taken to make the pregnancy last, when Tajwar was to be born. In spite of all precautions, he was born prematurely, during the 8th month. As the mother's health was delicate, he was only breastfed for a few weeks. 1½ years later, another boy was born and, when Tajwar had reached the age of 4, a sister was added to the family.

As it is often the case with premature babies, the boy developed rather slowly. He started talking at 2, walking at 3 and only stopped bedwetting at 4½. In spite

of this retardation, the parents trained him very early to look after himself, as they intended to send him to boarding-school as soon as possible. At 5, *i.e.* about 2 years after he had learned to walk, he was admitted to an English boarding-school in the hills. After a first term, the school report advised the parents not to send the child back, as he was too immature for the requirements of school life. He had proved to be dull and helpless in his studies, could not concentrate and had no understanding for the disciplined routine of a residential institution. During his holidays, his parents found him reserved, quiet and obstinate. If any of his wishes were not fulfilled, he would cry quietly or, if he had a chance, he would simply snatch away the wanted article. Though he was affectionate with his younger sister, he seemed to resent his brother, who had developed more speedily. The father was concerned about the possibility that this brother might pass beyond Tajwar in his studies. He seemed to be of opinion that the only remedy was to exert pressure on the elder boy, so that he might keep up his position. He was worried about the boy's anxiety, shyness and his childish clinging to his mother.

The 5½ year old boy was physically sturdy, but still of quite babyish proportions, with short limbs and a relatively big head. His sight was impaired by a squint, and his speech somewhat indistinct. Neurological examination showed some signs of immaturity of the nervous system.

In the few tests we administered, we could observe clearly that the child had no understanding yet for the nature and purpose of "education". All he had grasped, was arranging some letters and figures in groups that looked like words and sums, in quite senseless automatic imitation. He had not even learned to coordinate his movements properly. While one could elicit some interest in learning by using methods that appealed to his imagination, he needed no encouragement in playing. His purposeful use of toys, *e.g.* of bricks to build a mosque, his concern for tidiness, showed that he certainly did not lack intelligence. The fact, however, that by his being sent to boarding-school too early he had been placed before tasks and into a situation for which he was not mature yet, already seemed to have provoked secondary inhibitions through anxiety and confusion. We advised the father to keep the child at home and to send him to a nursery-school as a day-pupil. This was probably quite disappointing to him, as he seemed to have hoped for a wonder-drug which would bring the boy "up to the mark", by the time his next term would start.

Elements of spitefulness play a role in many neurotic manifestations of children. A first phase of opposition and self-assertion usually takes its course at the age of about 3, when the child begins to discover himself as a separate agent who can exert his will power against the surrounding world. A certain amount of spitefulness and stubbornness again are amongst the usual features of puberty, when a young person begins to realize and assert his freedom of action in other spheres. If reasonably dealt

with, such phenomena disappear, as development continues to a next stage. In some cases, however, spite may persist or reappear as a powerful method of defence against surroundings that do not recognize the child's needs.

Spiteful opposition of this kind was one of the salient features, though not the only symptom, in the following case :

- (74) *Shobha*, daughter of a Hindu clerk, was seen for 3 consultations at the age of 12½, before the physical signs of puberty had developed. Her father, who brought her, looked weak and miserable. His slinking posture gave him an air of helplessness. According to *Shobha*, he was seldom at home and, when he spent time with the family, he often displayed his bad temper. The mother also was described as irritable and of weak constitution. From the girl's description, we had to conclude that she occasionally went into hysterical demonstrations.

A first child of the marriage between these two inadequately equipped partners was born prematurely and only survived for a few months. *Shobha*, born next, was thus the eldest surviving child. After her, 5 brothers were born, the youngest one only a few months old at the time when we got to know the family.

The girl had a squint since birth ; but no one had ever undertaken anything against it, though in school she could never see what was written on the blackboard. Already when a small girl, she cried a lot, had temper-tantrums, developed some odd habits like scratching herself, and was generally restless. As, with this rebellious behaviour, she could not fit into any school, she was finally taught at home. She had learned quite a bit of reading and writing in Hindi, but showed neither interest nor aptitude for arithmetic. What we do not know, is whether her restless, quarrelsome and bad-tempered behaviour had been noted right from earliest infancy or only later. The fact that breastfeeding was stopped at the age of 2 and that shortly afterwards the first boy was born in the family, makes one wonder, whether she was displaced in her role of the only child by the arrival of a more favoured brother. In later years, sibling rivalry certainly played a prominent role. She resented being compared constantly with her brothers, who did well in school. Another problem she had to put up with, was the teasing she got for her squinting. Apparently not only her brothers, but also the neighbours ridiculed this defect. As no one stood up for her, she had to develop her own method of defence by beating the neighbours' children. While thus regarded as inferior as far as outward appearance and scholastic attainments were concerned, *Shobha* also had her strong points, on which she seemed to set a good deal of pride : As the mother was weak and sickly and preoccupied with the younger children, the only girl in the family had to learn very early to help with housework. At the age of 12, *Shobha* was practically the housewife. Getting up at 04.00 a.m., she would do all the cooking and other household chores and look after the frequently sick mother and the little brothers. At the time when we

examined her, she even told us quite proudly that these days, beside the work in her own home, she was also helping in the household of a sick aunt. Though this useful role not only seemed to give her the necessary recognition and respect in the eyes of the family, but also some self-confidence, one could not help doubting, whether this early burden may not have weighed too heavily on the neglected child. The attacks of moodiness, the fits of anger, in which she would tear her clothes, the headaches about which she herself complained, and the behaviour we ourselves were able to observe, all indicated internal conflict. Added to the present loads, were the prospects of an early marriage, which the parents were already discussing. During the few interviews at the Psychiatric Center, Shobha obviously could not decide at first, whether to continue in her proud defence of grown-up responsibility or whether to relax in accepting the chance of being, for once, a child. She first kept sitting with her head bent, resisting all attempts at friendly contact. Gradually, however, a few smiles escaped from this strict control. As verbal communication seemed impossible, the psychiatrist resorted to drawing a picture of the sulking girl seated on the "takhat". She explained that this girl in the picture would now stay with her and that, up to the next visit, the doctor would be kind to her.

During the next interview, when doctor and social worker both were giving time to her, Shobha went out to the waiting-room to fetch her little brother. The girl seemed to be so unaccustomed to getting any attention that had not to be shared with her brothers, that, having two people exclusively to herself, was just too overwhelming. (The author remembers having observed exactly the same reaction to receiving the doctor's attention, in a little Swiss girl of about the same age and in a similar family situation !) During the third visit, about 10 days after the first one, she went through a whole scale of different attitudes and emotions : first, for quite a long time, she stood stiffly behind a chair, holding on to its back. One felt that something was struggling in her behind this spiteful attitude :

Should she give up her painfully acquired defence of pride in being grown-up ? Could she afford to be a child ? Again the doctor tried to show that the girl had found a place in her concern by drawing a picture of the stiffly erect figure. Gradually, Shobha relaxed and became ready to talk.

We asked her about a "tīka" on her forehead, the kind of small, glittering metal disc which is stuck on to the skin. She explained that it belonged to her mother. In all probability, she had usurped the insignia of the housewife, whose duties she was actually performing. First she showed great concern about what might happen, if she lost the little ornament. She might have to pay for it. Later, however, she suddenly changed into a quite irresponsible mood, in which all the suppressed childish mischievousness, but also all the hidden resentment against her grown-up role, came out. She now declared that it would serve mother per-

fectly right, if the "tika" were lost. Then she expressed her bitterness about the father's plan to take a cousin-sister from the village into the family and to give her education in an English school. Hearing this girl's accomplishments so much praised, while her own efforts were taken for granted, hurt her very deeply. Towards the end of the interview, she very obviously tried to ventilate on the "mother-figure" which the doctor presented to her, the spiteful mischief for which she had no place at home. She started rubbing out the doctor's drawing of the standing figure, smeared and tore some other pictures that had been drawn for her and finally, with obvious satisfaction and an accompaniment of impish grimaces, she upset a glass of water all over the desk. The child was not brought back after this session. We do not know, whether perhaps the ice had been broken and whether she was able to relax so much that the parents considered her as improved, or whether, on the contrary, our permissiveness had released a flood of dammed up mischief, which made the parents doubt the wisdom of our treatment. In view of the miserable helplessness of the father and the hysterical tendencies of the mother, the latter possibility is the more probable one !

The fact that, in our group of neurotic children, we can demonstrate relatively few typical examples of spiteful behaviour, again must not be taken as indicating a general lack of such features in the general population of children. One can, indeed in street-life, during railway journeys or in restaurants and other public places, occasionally witness appalling scenes of children's spite and stubbornness. The popularity of methods of passive resistance and all forms of striking in India, probably lets such demonstrations appear as within the normal range of human behaviour. We shall, however, find a few examples of extreme spite in the group of "infantile psychosis."

A last example will illustrate at the same time what we have called "multiplicity of symptoms" and what one has to consider as a "borderline case" already approaching psychotic disintegration. In quite a number of cases, one felt that the inability to limit the conflict to one particular area and to a well defined symptomatology, marked a pre-psychotic stage.

- (75) *Samiun*, a Muslim girl from a village near Lucknow, gave her age as 11, when we first saw her. She was the last born of 12 children of a poor labourer. Due to old age and weakness, the father had already given up working. He was described as irritable. The mother, who brought the girl, seemed weak and helpless and went into uninhibited weeping, while giving the girl's history.

Of the 12 children, 2 had died soon after premature delivery, one was still-born, 3 further ones had died in infancy, and one girl after marriage and childbirth. Amongst the 5 left, one brother, at the age of 17, was the only earning member in the family. One sister was married ; the 2 younger ones, aged 15 and 13, often quarreled with our patient. Some other relatives lived together in the joint family.

Samun was born at term and without complications. She was breastfed up to the age of 2. Walking and talking were developed more or less at average age, but independent toilet habits only acquired at the age of 7. The girl received no formal education ; she only learned a few elements of literacy at home.

The symptoms for which the parents hoped to get a magic cure at our Center, were described as follows : the girl would go into fits of crying and angry abusing several times a day, particularly on seeing her father. Occasionally she would even lose control to the point of beating her parents. At the same time, she had developed some compulsive habits. She herself complained vaguely about anxiety and anger, fits of weeping and some pain in stomach, head and knees. From these two enumerations of symptoms, the objective and the subjective one, one can readily see that nearly all the main symptoms listed in Graph 2, were used in some way or other.

The family attributed her disturbed condition to what they vaguely called "some female trouble", probably meaning that she had not started menstruating yet. Of the first definite appearance of strange symptoms, they gave the following account : About $1\frac{1}{2}$ years before the first consultation, when the girl was aged a little less than 10 years, the family went for some outing and, on the way back, took a different route. Samun got very anxious and insisted on going back to the place they had visited, so as to return by the same route. The same compulsive performance was repeated by her when, about a year later, they went to visit some place of worship. Since then, wherever she went, she had to return exactly by the same route. She was obsessed by a fear that, unless she faithfully kept to this rule, she would become sick. At the same time, *i.e.* during the 6 months preceding our examination, she had started showing hostility against father and brother by flinging at them reproaches such as : "You rascals ! Are you not dead yet ? Get out of my sight !" Her hatred for family-members went so far, that often she refused to take food with them. Instead, she would go and eat with some neighbours.

There was something wild, fierce and unruly in the girl who, though the physical signs of puberty were not developed yet, impressed one as being more mature than many other girls of this age. The primitive little figure she produced, when asked to draw a picture of herself, was called "a boy". The cone-shaped body was marked with an irregular figure, a kind of triangle, with rounded corners, exactly in the region of the liver. We could not find out, what she meant by it : possibly the heart, possibly, however, some vague indication of genitals. The localisation of this extra addition was exactly the same as the "pain" in the case of Iqbal (71), who also suffered from compulsive symptoms.

Neither exploration of the girl herself nor of her parents produced much enlightening information. One got the impression that the "family-secrets" were being

kept tightly locked up. The fact that the girl mentioned anxious dreams about a "drunk man", her hostility against father and brother and the impression we got of the whole rather secretive and superstitious family atmosphere, made it highly probable that the girl had been the victim of some sexual approach, perhaps within her own family. Another possibility is that she resented the father's withdrawing from work and the family's poverty. These circumstances no longer allowed the automatic fulfilment of her wishes, after she had grown to an age at which her claims for good clothes, ornaments etc. could not be granted as easily as the simple needs of an infant. Again, as in the case of the Muslim boy with the compulsive features (71), the symptomatology betrays a strange compromise between contradictory tendencies : the compulsion of returning from an outing by the same route seems to indicate a fear of losing identity by moving away from the accustomed home-setting. The remedy for this fear, however, *i.e.* her setting out alone to repeat the journey according to her rules, seems to give proof of remarkable independence and interest in exploring the world on her own. Similarly, she on one hand clung to her mother like a small child, while at other times she cursed the whole family with death wishes.

This dilemma between a wish for individual emancipation and need for depending on those who provide for one, can be observed in one form or other in many psychiatric patients, —and in milder forms even in the so-called "normal" people of all ages ! Often, as in the case of Samiun, the conflicting inward tendencies are experienced through and in an outward situation : instead of recognizing one's own weakness and childish claims to be taken care of, one blames and curses those whom one suspects of keeping one in bondage. Or, in many other situations, one will accuse a tempting outward opportunity rather than the lack of resistance within, for leading one into wrong doing.

As we have mentioned earlier, a rigid pattern of compulsive habits, which at its worst can freeze into lifeless automatism, is by no means a sign of a particularly firm "inner structure", but often the last frantic attempt at preventing complete disintegration by surrounding the inner chaotic lack of structure and limitation by a kind of outward "plaster cast". One of the boys who will be mentioned in the group of "adolescent psychosis", will provide an instructive example for this : starting his trouble with the elaboration of various compulsive habits, he finally burst these artificial limits in a manifold display of aggression, ideas of omnipotence and, at the same time, all-pervading anxiety.

At certain stages of development, such compulsive protective shells may serve as a temporary scaffolding, while some inner reorganisation takes place or while some extra protection is needed after an exhausting illness. A certain compulsive ritual, either open or secret, can be found in many children. Individual and collective "culture", in fact, rely on certain compulsive practices for directing energies into harmless channels. Where, however, compulsive features in children persist or expand to more and more areas, or where they reach an unusual intensity, one usually has to

assume that some deep-seated insecurity and defencelessness has to be covered up by such manoeuvres.

A further feature which we could have added to our list of main symptoms, is "aggression". To some extent, either open manifestations or merely phantasies and dreams of aggressive character, were found in most children. In 14 cases, aggressive tendencies were particularly obvious. It is, however, rather problematic to draw the limit between aggression as a possibility which, in its widest sense, any normal person should develop and its "pathological" expressions. (The Latin verb "aggre^di" originally only means to go actively towards something". It has, however, assumed the restricted meaning of "approaching with hostility and violence". In some families, already a loud, indignant word or an annoyed gesture will be interpreted as "violence", while in others even a good-sized bout of physical fighting will be taken in the routine of the day. In many parents who were concerned or even horrified about any sign of vigorous protest or self-assertion in their children, one could sense that the fear was not so much determined by what the child actually might hurt or destroy, but by the vague apprehension that any manifestation of "violence" might find an echo in themselves and unleash, by "resonance" or "empathy", the never quite dominated, but only repressed, aggressive tendencies within them.

Some instances of aggressive tendencies have already been given in the cases quoted; others will be found in further case-histories, particularly amongst those in the chapter on "delinquency".

(4) *Local Origin* (See Table III).—A little more than half of the neurotic children came from Lucknow itself, the remaining ones, with the exception of 3, from towns and villages in UP.

Of the 4 children who had been brought up in completely rural surroundings, we have already presented Samiun (75). The 3 remaining cases, 2 boys and 1 girl, are all of puberty age. All of them including the already mentioned case, presented a variety of severe symptoms which made us classify them as "borderline psychosis". Anxiety was a prominent feature in all of them. With the exception of Samiun, these adolescents from villages were not what one would call real "villagers", but children from families that had already gone through a certain process of emancipation. All, except Samiun, had had education beyond primary standard. On the other hand, we have a few patients from farms, as e.g. the already quoted Jagdish (72), who came from the outskirts of big towns or from small country-towns, and who, though they were counted as inhabitants of towns, were of more characteristically rural type than 3 of the children from villages. These cases too were predominantly of puberty age. It seems that this class already follows a pattern similar to that found in our young adult patients, amongst whom quite a number, suffering from psychotic states or functional trouble, coming very close to psychotic breakdown, were brought from villages.

The one child from a Pakistan refugee family, Amrit Kaur (67), has already been quoted. There is no reason to assume that the fate of a refugee had any thing to do with her particular conflict.

6 children in this group had been subjected to one or more changes of local surroundings. The reasons were usually transfer of the father in some Government post or military function ; in other cases, however, dislocations stood in the service of education at residential institutions. In 2 children, change from village to city seems to have had its effect. Though such instability of the surroundings may have been somewhat unsettling, it cannot be accused as the main or even unique cause for the neurotic manifestations. In the two adolescents who were somewhat confused and oppressed by city life after a village childhood, one, a Muslim girl, had her freedom of movement at the same time curtailed by having to enter "purdah", while the other one, a boy of 15, found difficulties in his new college, which he entered at a time, when he was already in the midst of a puberty crisis. One boy, transplanted from South India, had some trouble with the new language and the teasing of his class-fellows. The neurotic tendencies, however, could be traced to a time long before the transfer.

There remain the "foreigners", whom, in previous chapters, we have mentioned in this paragraph on local origin. One Anglo-Indian boy will be quoted later, as he is the only instance of a child brought for consultation explicitly because of bedwetting. In his case, of course, migration had not played any role.

One American boy, aged 7, had been handicapped in infancy by a severe and long lasting disturbance of digestive functions ; later, his inability to assert himself against his more robust siblings, led to conflicts which he probably would hardly have been spared, if he had grown up in his own country.

One German girl of 9, had become the victim of her parents' marriage problems. It is possible that the father's prestige as a foreign expert, the freedom from the social and cultural pressure of his own country, had played a role in making him go astray in an Indian city, while in the sober "bourgeois" climate of his own home-town he might have kept closer to the ideal of a faithful husband and concerned father. A further disturbing factor for this sensitive child was lack of proper schooling in her own language in the guest-country, and the necessity for facing the additional strain of learning a new language, while the desertion of the father had already plunged her into emotional distress.

Again, not only these 2 foreign, but also our Indian examples, seem to show us that mere change of locality need not necessarily impress a child unfavourably, as long as the family environment provides a secure basis for assimilating the differences in the world outside the home.

Changes within the family, on the other hand, such as frequent absence of the father on "out-station duty", seemed to create problems in a few cases. We shall mention them in the paragraph on "lack of parents."

(5) *Community and Caste* (Graphs II and III).—The one salient feature in the distribution according to religious communities is, as we already pointed out earlier, the unusually large share of Muslims (33.3 per cent against the average of 19.7 per cent amongst all children), which reduces the Hindus to a mere 53.7 per cent, while in the previously discussed groups the figures for Hindu children (except in the small organic group, which is “all Hindu”), ranging between 68 per cent and 78 per cent, had come much closer to the proportion in the total population. This peculiarity is even more obvious in the group of infantilism, while in the two psychotic groups, the Muslims only contribute 9.1 per cent of the adolescents and none of the children. It may, however, be significant that, of the 12 cases marked as “borderline psychosis” in the neurotic group, 7 are Muslims.

We have already raised the question elsewhere, whether perhaps there may be some element in Muslim culture and attitude to life, that encourages neurotic solutions, *i.e.* preservation of a certain unity of personality and of contact with the “common world”, even under the stress of severe conflicts which might cause psychotic breakdown in a Hindu patient. Probably, investigations based on a greater number of patients and on an intimate knowledge of family life and patterns of child-rearing in both communities would be necessary to decide this question. From a more theoretical point of view, it would seem plausible that a strictly monotheistic religion, which discourages any imagery and any worship except of the one Allah, and a culture in which individual separateness is promoted through such practices as having different houses for male and female family members, viewing the world through latticed window and the veils of isolating burqas, may produce personalities who have learned to define their limits and relationships and who, in this atmosphere of hide-and-seek, have also mastered the art of mixing appropriate doses of revealing and concealing, in order to produce a wanted effect. The role of the Muslims as invading conquerors and later as disputed minorities, may further have contributed to the formation of a more definite personality structure.

Hinduism, on the other hand, with its accent on formlessness as the primary and highest condition, its attempts at defining by negation rather than by affirmation, its ideal of giving up worldly desires and differentiating attributes, its empathic-symbiotic family relationships, its wide tolerance and openness to all human possibilities, would seem to encourage rather an attitude that neglects limits and definite channels and which, therefore, would more easily react with complete disintegration or extreme withdrawal to any stressful situation.

Table 17 which lists the frequency with which the main and accessory symptoms occur in the different communities, may help us to throw more light on this problem. Again, only the figures for main symptoms will add up to the total number of cases. The percentage figures in these columns for main symptoms indicate, how big a share of the community in question presented that particular neurotic symptomatology.

TABLE 17.

Distribution of Neurotic Symptoms according to Community.

	Hindu		Muslim		Sikh		Christian	
	Main.	Access.	Main.	Access.	Main.	Access.	Main.	Access.
Neurotic Development	14 48.2%	—	4 22.2%	—	2 40.0%	—	—	—
Hysterical Manifestations	2 6.9%	2	2 11.1%	3	1 20.0%	—	—	—
Anxiety	8 27.6%	4	8 44.4%	—	1 20.0%	—	2 100%	—
Conversion Symptoms	3 10.3%	4	1 5.5%	6	— 20.0%	—	—	—
Compulsions, Obsessions	— —	3	1 5.5%	3	— —	—	—	—
Depression	2 6.9%	8	2 11.1%	2	— —	1	—	—
Infantile tendencies	—	5	—	2	—	1	—	—
Spite	—	3	—	1	—	—	—	—
Multiple symptoms	—	3	—	3	—	—	—	—
Borderline Psychosis	—	4	—	7	—	1	—	—

If we compare the two columns for Hindu and Muslim children, we find little similarity in distribution of the main symptoms. The figures seem, however, to tempt one into suspecting some kind of reciprocity between certain symptomatic categories. One will see that the figure for "neurotic development" amongst Hindu children (48.2%) is very similar to that for "anxiety" amongst Muslims (44.4 per cent), while, on the other hand, the percentage for "anxiety" amongst Hindus (27.6 per cent) comes close to that for "neurotic development" (22.2 per cent) amongst the Muslims. Furthermore, the percentages for "hysterical manifestations" and "depression" amongst the Muslims seems to have, so-to-speak, exchanged place in order of frequency with "conversion symptoms" amongst Hindus.

As manifestations like anxiety, depression, hysterical fits, were the predominant symptoms found in the more acute conditions, which caused parents to bring their children soon after the trouble had first manifested itself, one may have to examine, whether the Hindu and the Muslim group present any difference in the intervals between first appearance of symptom and first consultation.

Table 18, in fact, shows the expected inversion : While the medium ranges for duration of symptoms, between one year and 8 years, make out a fairly similar proportion for children of both communities, 48.2 per cent for Hindus and 44.4 per cent for Muslims, the Muslim children are concentrated, with a portion of 50 per cent, amongst the cases that were brought within one year of the first manifestation of neurotic trouble, while amongst the Hindus, this figure is only 31.0 per cent, the share with duration of symptoms over more than 10 years, on the other hand, almost 4 times as big as that in the Muslim group.

TABLE 18.

Duration of Neurotic Symptoms before First Consultation according to Community.

Duration of Symptoms before 1st consultation :	Hindu	Muslim	Sikh	Christian
Several Days	1	1	—	1
Several Weeks (up to 2 months.)	4	2	—	—
Several Months (up to 1 year)	4	6	1	—
1—2 years	2	1	—	—
2—3 years	2	2	1	—
3—4 years	3	1	—	—
4—5 years	2	1	—	—
5—6 years	3	1	1	—
6—7 years	1	1	—	—
7—8 years	1	1	—	1
more than 10 years	6 20.7%	1 5.5%	2	—

Should one conclude from this that Muslim parents are more observant or more concerned about any emotional disturbances in their children ? The similarity of the Hindu and Muslim percentages for duration of symptoms between 1 and 7 years and also for periods of up to 2 months, would hardly support this hypothesis. As to the small figure for cases of longest duration amongst Muslims, it is quite possible that some of the cases listed as "acute" may have presented minor symptoms or latent emotional distortion right from infancy.

The decisive factor, which we also again and again noted amongst our grown-up patients, seems to be far more that, if any Muslim,—in particular a woman—wants to draw the attention of his or her surroundings to some discomfort, problem or crisis, this has to be done in a sudden, loud and dramatic manner. Mild insidious disorders, characterized by withdrawal, gradual changes in character, subjectively experienced physical conversion symptoms, will risk to be overlooked or ignored.

Amongst our adult Muslim patients, particularly the women, we were often impressed by the more vividly dramatic nature of hysterical and hypochondriac features. In a paper on "Contents of Depressive Ideas in Indian Patients" (Hoch 10), the author commented on the fact that the manic-depressive syndrome amongst Muslims, in the rare cases in which we had occasion to diagnose it, is far more likely to manifest itself in the more demonstrative and dramatic manic form than in the silent suffering of depression. This is an observation which has also been made by some investigators studying Muslim patients in the Middle East and in the Mediterranean regions. We hesitate to assume that this phenomenon can be taken entirely as one of incidence, but wonder whether, in the fatalistic atmosphere of Islam, depressive states may perhaps be regarded as more or less normal, while only violently demonstrative symptoms like mania, dramatic anxiety and hysterical fits, can stir the relatives into concern and action. Amongst the few Muslim women whom we saw in a depressed state, there was one who had passed through several melancholic phases, lasting for years, before her brothers, who took their own minor depressive phases for granted, quite casually thought of consulting a doctor ! Perhaps the complete working through of our case-histories of adult patients will throw more light on the problem.

With regard to our group of children, we can only say that Muslims are brought for consultation more frequently with dramatic manifestations, like acute anxiety, hysterical fits, while Hindu children also seem to be able to provoke concern in their parents by more slowly and imperceptibly developing distortions. As to depression, the figures for children seem to contradict the observation just mentioned, *i.e.* that Muslims seem to tend less to depression ; the percentage of children with depression as the main symptom is almost twice as big as that amongst Hindus. Or might this observation perhaps, on the contrary, confirm what we assumed of the adults, *i.e.* that depressions occur amongst Muslims, but that, except amongst children, whose lives are less restricted, they deviate so little from the usual pattern of living that they are hardly noticed ? If the column for accessory features is also taken into consideration, depressive symptoms definitely predominate amongst the Hindu children. Compulsion, a symptom which also is likely to impress the surroundings, once it has gone beyond a certain degree which may merely be considered as "strictly orthodox", is more frequent amongst the Muslim children, both as a main and an accessory feature.

Unless these proportions reflect a real difference in the incidence of the various neurotic syndromes, one may ask, whether perhaps the more empathic communion in Hindu families keeps parents open to an intuitive understanding of the children's trouble, while the more pronounced individual separateness in Muslims may have to be bridged by more explicit and drastic means of communication.

In view of the high percentage of "borderline cases" amongst the neurotic Muslim children, the absence of Muslims in the group of "infantile psychosis" and their small number amongst psychotic adolescents, one may further ask, whether these "borderline cases", which still somehow seem to keep together, perhaps do not form so much

the equivalent of the neurotic as far more of the psychotic Hindu children. This again brings us round to our initial question : Are there perhaps some elements in Muslim culture and family life, which make for individual coherence and maintaining of contact in stressful situations, to which the Hindu reacts with total disintegration or withdrawal ? Once again, we cannot fully answer the question, but, on the basis of our small material, only formulate it as something that might be worth further investigation.

The number of Sikh and Christian children is too small to draw any conclusions about the distribution of the predominant symptoms. The only fact about these 2 groups, which may deserve mention, is that, in contrast to the Hindu and Muslims, amongst whom the ratio of boys and girls is approximately 2 : 1, girls are 4 times as frequent as boys amongst the Sikhs and even make up the whole number of Christians !

If we also attempt to examine, whether the distribution of neurotic children amongst the Hindu castes presents any particular features, we again face the problem of "small figures". Graph III indicates that the greatest number of patients belonged to the Baniya caste (31.3 per cent) ; Brahmins with 20.7 per cent and Kshatriyas with 24.1 per cent are almost equally represented, while the Kayasth children only form a small share of 10.3 per cent. Apart from this modest percentage of Kayasths amongst neurotics and the 18.7 per cent in the group of infantile psychosis, this caste excels by absence in the remaining functional groups. The author does not feel competent to give any interpretation for this fact, at least not until the figures for grown up patients will have been fully investigated in this respect.

It may, however, be worthwhile examining, what symptoms are predominant in children of the different castes. As far as the small figures can give any plausible indication, one would conclude that, for Brahmins, an overall neurotic development is either the most frequent expression of conflict or that which is most likely to provoke the parents' concern. Hysterical manifestations and anxiety as the main symptom occurred in one case each. As accessory symptoms, depression, anxiety and infantile features are most prominent. Multiplicity of symptoms and threatening psychotic disintegration were noted in one case each. Of the Kshatriya children, we again find the greatest share amongst those with "neurotic development". Conversion symptoms (both cases stammerers !), take second place, while anxiety and depression were noted once each as main symptoms. As accessory features, one finds anxiety, conversion, compulsion and infantilism. In this caste, we seem to find, on the whole, forms that favour deeper repression more than superficial manifestation. This may correspond to the observation that, amongst adult patients, Kshatriyas, together with Baniyas, form the main portion of the group of endogenous depressions, while Brahmins have more affinity to the group of schizophrenias. The few Kayasth children all presented general neurotic development ; in one case, infantile features were marked as a particular characteristic. May one, perhaps, venture the explanation that, in this highly "cerebralized" subcaste of clerks and administrative officials, the present-day fashion of

intellectualisation and higher education has not significantly broken or changed any tradition, but fits into an already established pattern, so that breakdowns are less likely to occur during the phase of education than perhaps in later years ?

The Baniya children, who form the greatest share in the Hindu group, seem to tend mainly to anxiety in its open manifestation and less to plain neurotic development and conversion. Depression, frequent in its endogenous form amongst adult Baniyas !—figures prominently amongst accessory features, with hysterical fits and conversion symptoms taking second, compulsion and spite third place. The relatively high proportion of borderline cases and multiple symptoms, together with the remarkable accumulation of cases of open anxiety, make one wonder, whether this caste has been particularly exposed to new, unaccustomed patterns of living, in which the traditional supports of material wealth and prestige and abstention from physical work and personal service no longer provide a substitute for the development of individual firmness and limitations.

Of the two Shudra children, we find, in one small girl, hysterical manifestations with an infantile admixture, in one adolescent boy (Jagdish, 72) depression. Already now, however, we have to point to the relative frequency of Shudras amongst the psychotic adolescents !

(6) *Occupation of Father or Guardian* (Graph IV b).—The business-class, the sector of junior service and academic professions plus higher posts in service, are represented amongst the families of neurotic children in almost equal proportion, the frequency only slightly decreasing in the order in which they have been mentioned. Corresponding to the smaller share which academic professions and high service positions form in the general population, this proportion indicates a relatively greater frequency of neurotic children in this class. Again, one can either suppose that high cultural and educational demands may expose these children to greater stress, or that perhaps their parents are simply more sensitive to even subtle troubles or better equipped to seek adequate treatment.

What is rather surprising, is the relatively big portion of children from farms (small farms and bigger landowners together 12.9 per cent). It may again be interesting to study the symptomatology of these children : In 5 of them, anxiety is the main feature, in one hysterical fits, in one depression. As accessory features, we find hysterical fits, conversion symptoms, depression and, in one boy, compulsion. One boy presented a great multiplicity of features, and 2 girls were on the borderline to psychosis. Again we find a predominance of those features which we have seen as typical in the more acute manifestations of neurotic trouble. Except for one Muslim zamindar's daughter, who had been delicate since infancy, all children actually were brought for consultation within one year of the start of manifest signs. With the exception of one boy aged 10, all belong to the age-group 14 to 16.

This distribution again seems to confirm our suspicion that acute and poorly disguised manifestations of anxiety may be precipitated by the need for emerging from well sheltered traditional surroundings into a modern competitive and individualistic society.

(7) *Joint and Individual Family.*—If the statement at the end of the last paragraph is true, we ought to find a similar distribution of neurotic features, *i.e.* a predominance of the more acute and superficial symptoms, amongst the children who have to grow out of the protective climate of a joint family. As our data about family status are more precise for the neurotic children than for the previously discussed groups, and as, furthermore, the share of known joint families, with 33.3 per cent is biggest in this group, this question may be worth investigation.

Graph 3 shows 2 separate sections, for main and accessory symptoms. In each column, the dark marking indicates the number of children from joint families, while the rest of the column contains the cases from families which either were definitely “nuclear” or about whose status we were not quite sure.

Amongst the main symptoms, anxiety is most frequent absolutely; hysterical features and depression occupy an equal second rank. Neurotic development was diagnosed in 2 of the 18 cases, conversion and compulsion in one each.

The relative figures, comparing the frequency of a symptom in children from joint families with the number of all children who presented a certain type of symptom, show a quite different ranking : As the one case in which compulsion is the main feature is the only one in the whole material (Iqbal, 71), it leads with 100 per cent. Next comes depression with 75 per cent, then hysterical manifestations with 60 per cent and then only anxiety with 42.1 per cent. Neurotic development and conversion only claim small portions of this group. If we try to establish the relative priority amongst the accessory features, compulsion again leads with 66.6 per cent, followed by hysterical symptoms with 60 per cent and depression with 36.4 per cent. Anxiety, which seems to dominate the picture in most cases, where it occurred, is insignificant as an accessory factor.

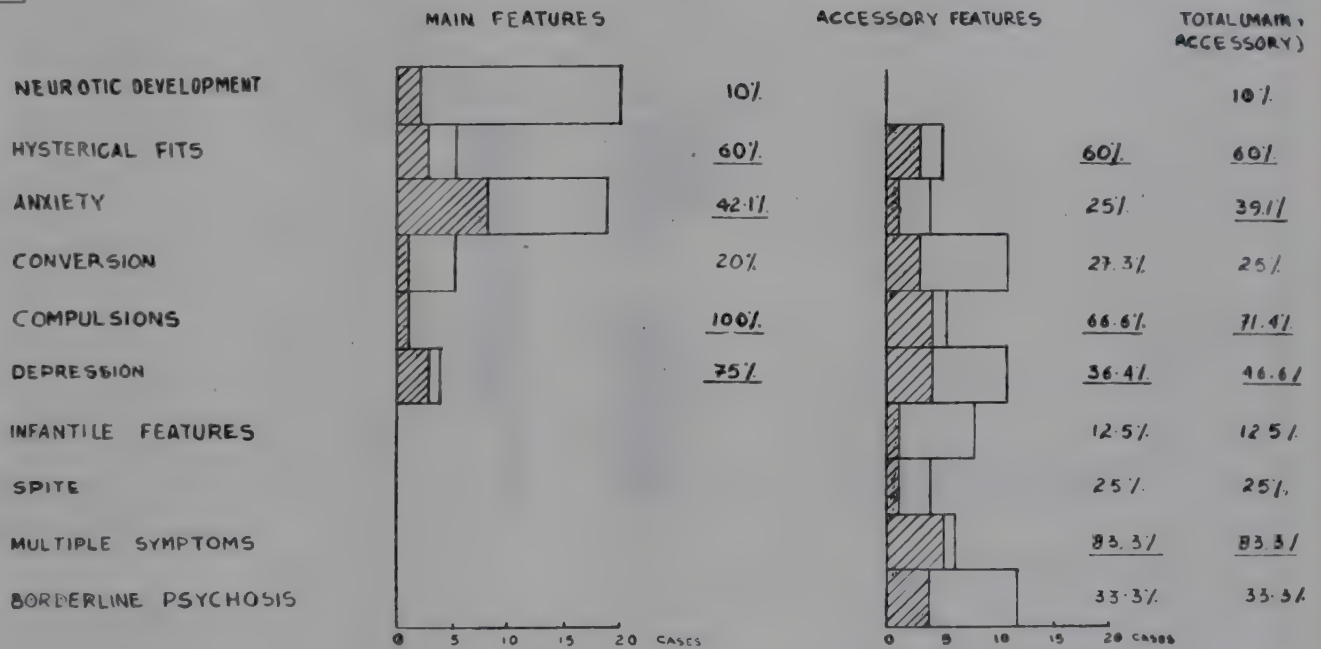
If both, main and accessory features are taken together, we still find compulsion as the most frequent feature, with 71.4 per cent of all children who presented such symptoms. The next symptomatic group in which children from joint families predominate, with 60 per cent, is that of hysterical manifestations. Next comes depression, with 46.6 per cent, and only then anxiety with 39.1 per cent, *i.e.*, a percentage still higher than that of children from joint families in the whole group. All other figures are below the average of 33.3 per cent, except that for “borderline psychosis”, which, with 33.3 per cent, goes exactly parallel to the share of children from joint families in the whole group of neurosis, while the cases in which a great multiplicity of symptoms was noted, accumulate to 83.3 per cent amongst the children coming from joint families !

Graph 3.

Neurotic Symptoms in Joint and Individual Family

 FAMILIES KNOWN TO BE JOINT

 ALL OTHER FAMILIES

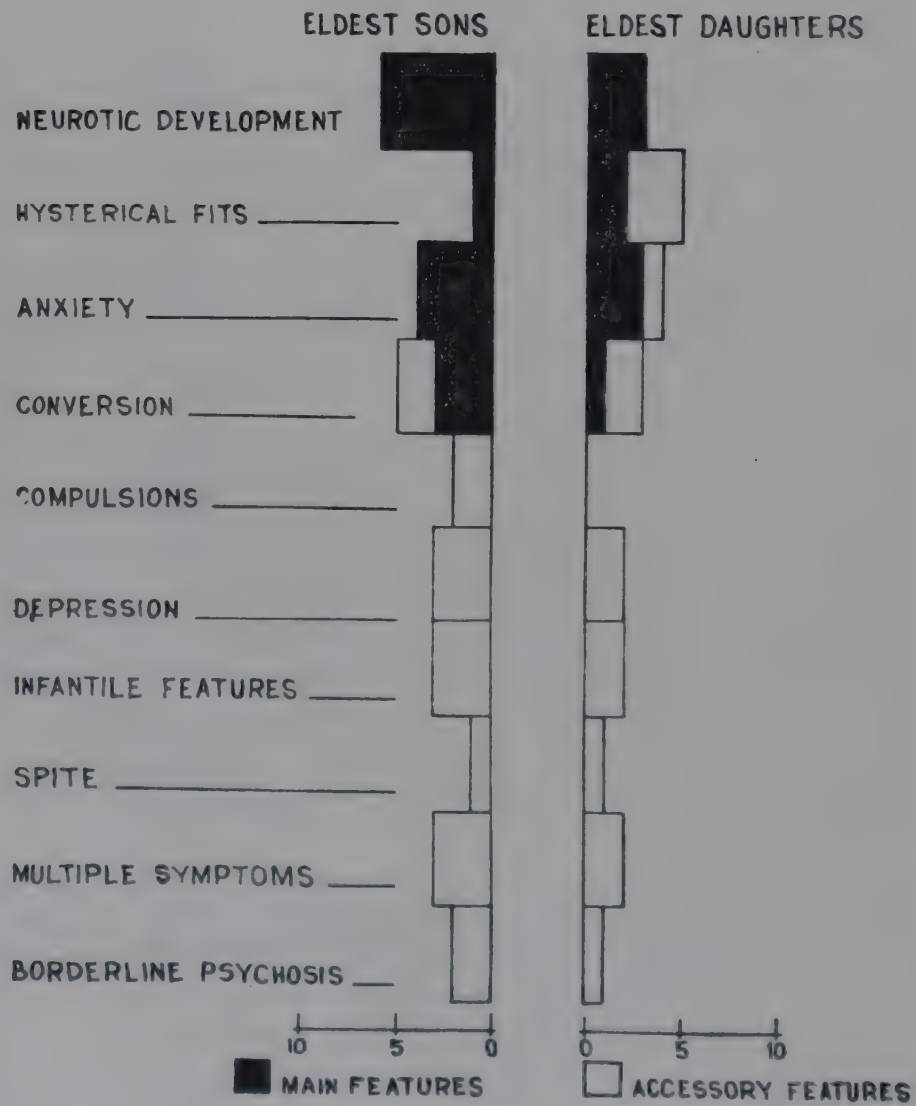


PERCENTAGES = SHARE OF CASES COMING FROM JOINT FAMILY FROM EACH COLUMN
 PERCENTAGE OF JOINT FAMILIES IN TOTAL GROUP; 33.30%

Graph 4.

Neurotic Symptoms in eldest sons and daughters

(Text see page 243)



It therefore seems that anxiety, while one of the most frequent symptoms for which children from joint families were brought for consultation, is relatively not much more frequent than amongst children from individual families. Compulsion, hysteria and depression, however, which are amongst the rarer manifestations in the total material, seem to occur with preference amongst children of joint families.

In the West, ostentatious compulsive syndromes as well as demonstrative hysterical manifestations tend to be regarded as rather "old-fashioned". What may give compulsion a favoured status in the Indian joint family, could be the persistence of orthodox customs. They are most likely to be preserved in the joint family setting, where the older generations have more opportunity of influencing the younger ones. Thus, orthodox rituals would not only provide a pattern for compulsive symptoms, but the joint family would at the same time form a credulous and appreciative public for manifestations of this kind. Furthermore, we have seen that, in many cases, compulsion seems to be a rigid defence against threatening disintegration ; it might therefore be an apt compensation for the lack of individual limits in the empathic atmosphere of a joint family.

Psychiatrists and psychologists who have worked in cultures where "extended families" still exist, stress that children who grow up in this collective form of living, do not identify as uniquely with one of the parents as a model as children in the nuclear family. As this identification, however, is a decisive factor in shaping the ego after a definite model, its absence or diffuseness would tend to prevent the establishment of firm ego-boundaries.

Hysterical manifestations, as we have hinted earlier, might thrive where the need for excusing oneself from "social usefulness" is not very pressing and where, furthermore, the neurotic symptom has to convince an audience and not only the patient himself. Both these conditions are provided in the joint family.

While these two symptoms, therefore, might be more calculated to maintain a position still within the joint family, anxiety and depression might perhaps be the responses to having to emerge from the safe shelter of collective living. If we examine the individual cases, we find in fact that, in the majority of children in whom anxiety and depression represented the main symptoms, some factor was present which disrupted the joint living : either the child's leaving home for higher education, the prospect of marriage, or then the absence or death of an essential family-member or, in one case, discord and lack of interest in the common cause within the joint family. The compulsive and hysterical symptoms, on the other hand, were found amongst children who were still fairly firmly embedded in the joint family structure.

From this, one may see again that a particular feature *e.g.*, a child's coming from a joint family, may not be decisive in itself, but that, in each case, we will have to see the particular implications. In the present instance, for example, one has to examine,

whether it is the atmosphere of a still intact joint family that encourages certain manifestations more than others, or whether it is, on the contrary, the disintegration of this particular family structure or the emergence from it, which may precipitate certain neurotic reactions.

Examples of children from joint families have already been given : Two Muslim children (Samiun, 75 and Iqbal, 71) and the Sikh girl Amrit Kaur (67) from relatively intact joint families ; Uma Shankar (69), shaken in his security by death of the mother and later by life in a hostel ; Jagdish (72) to whom, after the death of the father, the small joint family, instead of providing a shelter, had become a burden and responsibility.

(8) *Lack of Parents* (Table VI).—With 12.9 per cent, the percentage of children who had lost one or the other of their parents, is only slightly higher than the average for all groups (9.6 per cent), but still somewhat bigger than in any of the major congenital-organic groups.

The case of Jagdish (72), who had to shoulder early responsibilities after the death of his father, has already been quoted. Of the 4 children who lost their mothers, we are already acquainted with Uma Shankar (69). In 3 of these 4 children, as well as in little Caroline (68), the foundling child who had lost her mother at birth, the main or even exclusive feature was anxiety, in one boy depression. One orphan-boy, who had been adopted, but who did not know about his true origin, reacted to his situation with delinquent features, but also a certain amount of depression.

Stepmothers, though present in 2 cases, do not seem to have played their traditional witch-like role. Both children whose fathers had got married again, (One of them Uma Shankar, 69), were mainly brought up by other relatives and only had casual relationships with their stepmothers.

Separation or divorce of the parents, except in the case of the little German girl, was noted in none of the families.

4 fathers, however, were kept away from their families by their professional duties. One of these cases has already been quoted extensively elsewhere. [Hoch (24)]. It is, however, so typical of the situation of an adolescent who loses the support and model of his father and, beyond this, is supposed to assume additional responsibilities, just at a time when he is engaged in struggle on the inner front, that it deserves to be presented again in this context :

(76) *Rehman* was the third of 5 children and the eldest son of a Muslim family. His father, who brought him for consultation, seemed rather reserved, of worrying nature. He admitted that at times he went into severe fits of anger. The boy's mother was described as irritable, very compulsive about cleanliness and about her religious duties. Under her influence, Rehman also, quite early in childhood, had started to develop compulsive habits of washing his hands very

frequently and of taking a long time for his bath and toilet. It seems, however, that no one attached any great importance to these habits. Only quite recently, during the last 3 weeks before consultation, the parents had become concerned about the boy.

He had started expressing fears about going out alone and insisted that someone should accompany him, wherever he went. He even refused to go to school alone. The father could only tell that the boy had expressed the idea that all strangers in the street looked like dead bodies. He explained that this puzzling symptom had developed in the boy since he, the father, had been transferred in his work to a different city, while wife and children had continued to live in Lucknow in the joint family. When hearing about the boy's trouble by letter, he had come back to arrange for his treatment.

During his first interview, Rehman, who was fairly well developed for his age and showing the first signs of puberty, already explained his trouble with great confidence. For the last 2 months, he had felt anxious, when leaving the house alone. Whenever he saw strangers outside, he thought that he might kill them. It did not matter, whether they were men, women or children. The only criterium was that they were unknown to him. If they were his friends or acquaintances, he did not get this idea. On the other hand, if any one he knew was with him, even if it was only a small child, he also felt safe. When going on his bicycle, he got the idea that he might run someone over ; so he had given up cycling. For the same reason, he refrained from football and other violent games and even from quarreling with his friends. Whenever he arrived at home, he wondered, whether he might not have killed someone. Even when sitting in school and looking out of the window, he had such thoughts about the unknown people walking about outside. He also feared that he might hurt someone, if he only accidentally knocked against another person. He demonstrated to the psychiatrist that, after touching the chair he was sitting on, he had to control, whether his hand had not left a mark of blood.

On direct questioning, the boy denied any anger or conscious reasons for aggression. He admitted that, since his father had gone away, being the eldest son, he had to take over more responsibilities and to face more unfamiliar situations, *e.g.*, in going to the market or for other errands. But he hastily, perhaps all too hastily ! added that he liked to do this work, that "his heart was in it". In the projective tests, however, his aggressive thoughts and his guilt-feelings came out clearly. There was also some evidence that he had been worried by night-emissions ; possibly he had been masturbating and was feeling guilty about it.

A factor that might have contributed to the formation of the symptom was that, shortly before, public indignation and curiosity had been stirred by a series of mysterious murders in a neighbouring town, performed by an unknown person

on equally anonymous victims, like beggars sleeping in the open. He had also witnessed some quarrels and fights in his mohalla and some student-riots, but had not been engaged in any fighting himself.

On physical examination, we found discrete signs of some organic brain-damage. He had had a fall in his childhood, and it is possible that it may have left some scar in the brain tissue.

Rehman himself was eager to come and get our help. His father, however, though he seemed to be very concerned about the boy in the beginning, apparently was only out to get a certificate for himself, so that he could be transferred back to Lucknow in the interest of his boy. Once we had written this certificate, for which of course there was some justification, he did not bring the boy back for treatment. We strongly suspected that the boy's symptoms may partly have been a reflection of his immature father's reluctance to stay in a strange city away from his family. If the boy's symptoms could not have served as a convenient excuse for manipulating the father's transfer back to Lucknow, it is very doubtful, whether the parents would ever have taken so much trouble to have the boy examined.

It was of course possible that the father's presence in the home would cover up the boy's symptoms for the time being. Meanwhile, however, particularly as the father himself was a weak figure, the conflict was likely to develop insidiously under a bland surface. In his fear of his own aggressive tendencies, he might have further restricted the radius of his activities and thus might have got into an ever tightening vicious circle of aggression, suppression, fear and tension. As he seemed to be in great danger of being overwhelmed by his "anonymous" and uncontrolled aggressions, we have also included his case in our small group of "potential delinquents".

This history of a "puberty crisis", presents many interesting features : Rehman is one of the young patients who, in an acute state of anxiety, though after a preliminary stage of mild compulsive manifestations, experimented with a whole variety of symptoms that might help him to tie down the vague, all-pervading sense of insecurity into a more definite and more manageable symptom. While, under the father's rule and perhaps with the help of compulsive practices learned from his mother, he seemed to have succeeded in keeping his aggressive tendencies suppressed, they rose in very threatening fashion, as soon as the father's absence slackened the outward controls. This shows that no proper inner control had been established yet. The insecurity in having to venture out into new sectors of society and new responsibilities, is perhaps reflected in the fact that he only thought of killing people who were unknown to him. It is quite possible that, originally, this fear of killing may have had more passive character and that he may only have transformed it into an active phantasy secondarily, in the service of self-defence. A person to whom one is not known and whom one does not know, can so-to-speak not confirm and support one or, to put it more extremely, cannot grant one an "existence". Furthermore, on meeting a stranger, one risks

to be "contaminated" by "matter" which one has not learned to assimilate yet. This, however, means annihilation or "poisoning", and may call for a preventive or defensive move. Possibly, to give another interpretation, the aggressions may have been turned against "unknown" people, because they themselves were still vague and unrecognized. Seeking anonymousness in the outlet of aggression, is a sign of immaturity, of lack of self-knowledge and self-control. The mature man can identify and localize his aggressions ; he can choose, whether to express them in a given situation or whether to keep them back and to allow them a legitimate outlet in some vicarious manner, *e.g.*, in sports, debates or, quite generally, in a sublimated form in the struggle of life. The adolescent, in his immaturity, is flooded by the aggressive impulses, which should become a normal ingredient of his manhood.

The guilt-feelings about these aggressive tendencies, in their turn, may increase the anxiety and fear of being exposed as "bad". In Rehman's case one can easily imagine that, from the preoccupation about his leaving a trace of blood on touching any object, it would only take a small step to invest his neurotic conflict in an intensification and prolongation of his already exaggerated habits of cleaning and washing into a real "Lady Macbeth complex". A compulsive solution of this kind, keeping him busy for a great part of the day, might at the same time dispense him from his extra duties and from having to venture out of the house amongst strangers.

If even in a joint family, in which other adult men continue to present authority, the absence of a father at a critical moment can have so decisive an effect, we must assume that in a small nuclear family it will be felt even more :

- (77) *Kamal Kishore*, a boy of 8, attending 4th class, was brought by his mother, because of his bad-tempered, restless and irritable behaviour. The main complaint, however, was that recently the boy had suffered from frequent urinating. He had to pass water several times an hour. At night he had no restful sleep, but would kick and cry.

The boy was the eldest child and only son, born after 9 years of childless marriage. He had 2 sisters, one 4 years, the other one 6 years younger. According to the mother, the father had suffered from tuberculosis during the first years after marriage and had been very demanding, irritable and unkind with his wife. Even when at last she was pregnant, she still felt nervous and insecure. After a normal delivery, the mother only had little milk, and the boy had to be given tinned baby-foods. He developed blisters in his mouth and vomited frequently up to his second year. During infancy, he also suffered from liver-trouble. At the age of 3, he had a severe attack of typhoid. As his restlessness and mischievous behaviour started mainly after this illness, one may even wonder, whether the infection may not have involved the nervous system more specifically, perhaps even in form of an encephalitis. No physical signs of organic damage were found, and even detailed investigation at the Children's Department of Lucknow Medical College,

could demonstrate no physical cause for the urinary trouble. We therefore had to assume that restlessness, temper-tantrums, night-terrors and frequent, almost compulsive urinating were all in the service of some neurotic conflict. We regarded the frequent urinating,—often a physical sign of anxiety and tension,—as a “conversion” symptom ; one will, however, see that it also has a certain compulsive character.

During the 3 interviews for which the child was brought, we were not able to gain any enlightening information either from him or the mother. Even some of the facts already included in the history given up to now, were only found out, when, a few months later, the mother presented herself as a patient. She was vexed by her own compulsive habits of cleaning and washing, which, according to her, had developed since her husband had been posted to a job outside Lucknow about a year before. She had not mentioned this trouble of her own, when she had first come to bring the boy for consultation. Hearing this, we wondered, whether the boy's frequent urinating had been a protest against the mother's excessive cleaning and compulsive horror of excrements. We have seen, in other cases, that the carelessness about excretory functions in one family-member closely matched the cleaning compulsion of someone else in the same family. In this case, however, it is interesting that the boy's reaction itself took on a rather compulsive pattern ; again an illustration for the fact that the compulsive defence does not really lead away from what one wants to avoid, but actually takes one into the midst of it, subjecting one to constant bondage.

An enthusiastic Freudian might perhaps have pointed out that this only son, as actually already Rehman in the last example (76), had been brought into an obvious “Oedipus situation” through the father's absence and that he might have chosen the symptom of frequent urinating as a compromise between demonstrating his “penis-pride” in his role of father-substitute, and at the same time guarding himself from “incestuous” closeness to the mother by showing himself hostile and irritating to her !

We cannot, in this connection, go into a deeper analysis of the mother's trouble, of which the boy's symptoms seemed to be a mere reflection or complement. It may, however, complete the picture of the family-atmosphere, if we tell that the mother gave us as one of the reasons for her compulsive cleaning and washing that, just about at the time, when the husband had to leave the family, an unpropitious constellation had taken command in her horoscope. This “evil star”, threatening disaster, had to be propitiated by the compulsive rites. At the time when the woman consulted us for herself, the period of danger was almost over, and she hoped for some improvement even without our treatment.

Both, the compulsion and the literal acceptance of the astrologer's warning, whatever deeper conflicts they may have been concealing, certainly revealed considerable insecurity and ambivalence with regard to her husband. We suspect

that, in this case, it was perhaps not so much the absence of the father in itself, but its effect on the mother, against which the boy had to defend himself by his symptoms.

Absence of the mother, who was mentally ill and roaming about near some pilgrimage place, seems to have been partly responsible for the rather dramatic manifestations of anxiety in an adolescent Muslim girl, whose history, however, will be given more profitably in some other connection. (92).

Mothers who neglected their duties towards their families because they worked outside the home, were found in 5 cases, including that of the little Anglo-Indian boy. Two of these women had to earn for their families, one because the husband was mentally ill, the other one, foster-mother of the adopted boy, because her husband had left her. The first mentioned of these 2 cases, deserves to be quoted, not only because it reveals the pathetic plight of this one little boy, but because similar cases may become more and more frequent, if more women leave their natural duties in the family, either through bitter necessity or, as in the other 3 cases in our group, because of ambitions for greater material prosperity or social emancipation and prestige.

(78) Before we got to know *Pradeep* at the age of 10, we had already examined his father, a quite irresponsible man, who took no care of his family. We got the impression that the father may have been mentally deficient right from birth, but that considerable functional trouble, almost of the nature of schizophrenia, had superimposed itself on the original weakness. At 33, he still behaved as spitefully as an adolescent against his father, with whom he lived in joint family. There was no trace of grown-up dignity and concern in him. He would playfully engage in some "business", but invariably fail and then again appeal to the generosity of his father to cover the loss. If, on the other hand, he was restricted in his activities and denied the means for such imprudent enterprises, he would go into fits of temper and beat the children, in particular our patient, who seems to have been the most helpless one.

Two of the father's sisters had suffered from mental breakdowns. The paternal grandfather was a fairly reasonable and kind man, but was gradually getting fed up with having to support his useless son's family, and he also resented *Pradeep's* lack of smartness.

The mother, who did her best to cooperate with us in helping the boy, and who derived some comfort herself by unburdening herself in talks with our social worker, was a sensitive, delicate woman, who had suffered from tuberculosis and at times still went through minor active phases of this disease. In spite of this, she had taken up a post as social worker in a Government agency. This work often kept her away from home for days or even weeks. One can imagine, how much of her concern a "social worker" can give to her clients, if her own heart is burdened with worries about her family ! In addition to this work,

which seemed to claim most of her strength, she was trying to study for some exam which would qualify her for a better position. She fully realized that her absence had a harmful effect on the sensitive boy, but could see no other way out of the depressing situation.

Pradeep was the second of 4 children. One brother, two years older, was more robust and seemed to find his way in life fairly well. A younger sister had died of liver trouble at the age of 6. One sister, aged 3, was healthy.

When Pradeep was born, the father was already mentally ill. Though the mother was suffering from tuberculosis, she kept on breastfeeding the boy for 20 months. For some time, she went to her "maika", where the boy was looked after by his aunt and grandmother. From earliest infancy, he was very quiet and hardly ever cried to announce his needs. He learned to walk at 2½, to talk at 4, but had already acquired control over his excretory functions at the age of 1½. After returning to his own family, together with the mother, he was scared of his father. He remained quiet and withdrawn and hardly showed any inclination to playing.

Already at the age of 6 months he had, like all children in the family, suffered from infantile liver trouble. When aged 4, he had an attack of typhoid and, at 7, went through small-pox.

At the time we met him, aged 10, he had reached 4th class in school. He showed some interest in learning, but in his dreamy aloofness had difficulty in concentrating. At times, when he was not in a mood for going to school, he would "pretend" a headache or some stomach upset. It was, however, not only this inability to learn, his absent-mindedness and his occasional stubborn behaviour that had made the mother bring him to us, but the fact that, during the past 1-2 years, *i.e.*, since the age of 8-9, he had almost given up speaking. He would still communicate with his mother, whenever she was at home, but when she was on out-station duty, the only person whom he dared to tell about his needs, was the elder brother.

As the boy himself insisted on coming for regular interviews about once a week, we had a prolonged opportunity of observing and treating him during 37 sessions distributed over a period of 15 months. He was the boy, mentioned earlier, who implored us under tears, through the telephone, not to stop his interviews, when the family wrongly took a "free service statement" as a bill to be paid.

In the beginning, he was dreamy, shy, inhibited, looking rather younger than his age, though physically he was adequately developed. For weeks, he would hardly speak a word during his therapeutic sessions. As the therapist also, not having learned sufficient Hindi yet at that time, could hardly talk to him, everything went

on in silence, through "non-verbal communication". The boy showed himself quite clever in doing some performance tests. At times he would seem blocked before a tricky task ; but then a sudden intuitive flash of understanding would lighten up his face and he would triumphantly solve the problem.

Just as in speaking, he was very much inhibited in expressing himself by drawing, at least in the beginning. He would only copy faithfully whatever the doctor drew for him. After a few interviews, when he had already "thawed up" a little in the permissive atmosphere, he began to enjoy using paints more boldly. This activity, however, seemed to follow the principle of "all-or-nothing", which obviously governed much of his behaviour, including the almost complete blocking of speech. He would either produce a rigid system of straight lines or then completely confused tangles of odd, random shapes and blots of colour. At times he worked himself into a real frenzy of smearing, often using both hands simultaneously for two different activities, accompanying this orgy by satisfied grunting sounds. In his rare attempts at drawing human figures, he would leave away the main body and just add arms and legs to the head. Similar human figures were produced in plasticine.

Small plasticine figures made for him by the therapist, provided the material for staging dramatic scenes, in which he was able to abreact on a small and harmless scale some of his suppressed aggressive tendencies. In the beginning, when any scene of threatening attack, *e.g.*, by a plasticine snake, was presented, he would react to it by making the human figure run away or hide. Later, however, with great satisfaction, he used the paper-knife for beheading the snake.

After a few weeks he had become so confident in his mute relationship with the psychiatrist, that he dared to ask her, though still by gestures only, to attend to some boils he had developed. Later, he would even seek physical closeness without any "medical excuse" of this kind.

At a still later stage, he developed interest and pleasure in ball-games. It took, however, quite some time until he could catch the ball in a receiving gesture; his first impulse was to push it away in a defensive movement.

After 4 months of weekly interviews, when he had started speaking occasionally, he showed unmistakable signs of "backsliding". He again looked closed up, anxious, withdrawn, but fortunately still was able to use paint-brush and colours for ventilating some pent-up aggression. We later learned through one of the relatives that, shortly before this setback, the boy had been severely beaten by his father. This apparently had driven him back into himself. An example of a situation in which the father would react with angry beating was once related by the mother : Pradeep was supposed to do his home-work for school. His father, however, had been lying down on the book the boy was supposed to use. The father,

while himself "loafing", would scold and reproach his son for not learning. The boy, on the other hand, would be too scared to explain about the book which he could not reach without disturbing the father, and would freeze stiff in his anxiety. The scene would end up in a severe beating by the enraged father.

While, thus, the father's behaviour was certainly to a great extent responsible for the boy's scared withdrawal, one could distinctly notice a loosening up into greater liveliness and cheerfulness, whenever the mother had a chance for staying at home. Gradually, the boy's progress seemed to continue more steadily, irrespective of changes in the home atmosphere. He began to develop great zeal in constructive activities, such as framing pictures and making cardboard boxes, and obviously was proud to take these products home to the family. By that time, he was speaking quite freely.

His growing ability not only to take in more of the world, but also to give, was demonstrated in a rather touching way, when, 7 months after the start of the treatment, he spontaneously offered to have the doctor's ball-point pen repaired at his grandfather's shop. He quite conscientiously brought back the repaired article, when he came for his next interview.

During the last few sessions, one got the impression that, though he was still somewhat restless and unorganized in his activities, the boy had "found his feet" and that his continuing to come for the therapeutic interviews merely served to give him some additional security and confidence. He finally decided himself to close the treatment, when he no longer felt he needed it.

One may hesitate, whether a case of selective mutism of this kind should still be counted as a depressive neurosis or whether it already deserves the name of a catatonic (*i.e.* psychotic) reaction, which should find its place in the group of psychosis. As, even without speech, the boy, right from the start of the treatment, showed a fundamental willingness for contact and relationship, which gradually developed into a fairly free exchange of give-and-take, and as environmental factors seemed to play a significant role, we felt justified in still considering the boy's development as neurotic.

(9) *Heredity* (Table VII).—The figures for incidence of psychiatric disorders amongst the relatives is slightly higher in this group (46.3 per cent) than the average percentage (43.7 per cent) for all children. It is, however, significantly smaller than that for the two psychotic groups.

Functional troubles amongst the relatives definitely predominate over those of organic and congenital type, at a rate of 5.3 : 1. What one might call "specific heredity", *i.e.* the incidence of neurotic and psychosomatic troubles in the family, reaches the considerable figure of 38.8 per cent. Next in size comes the figure for psychosis with 18.5 per cent. Again, however, we have to guard against considering

this "heredity" as a weakness which is transmitted all ready-made by a particular constellation of genes and chromosomes. What is "inherited", may only be a certain sensitivity, a lack of protective shell against outward influences. Whether and in what particular form this disposition actually gets a chance of expressing itself as a neurosis, will, to a great extent, depend on environmental influences.

Amongst these influences again, manifest neurotic reactions and attitudes of the closest relatives, will decisively determine the family-climate, so that, what may appear as "heredity", may merely consist in a process of postnatal conditioning. Any functional distortion in the parents is of course most likely to have its effect on the child. The table on "parental heredity" (Table VIII) is therefore likely to give us more relevant information than the one on "general heredity".

The figure of 38.8 per cent for parental heredity indicates that the majority of psychiatric disorders mentioned in the table on "general heredity", occurred in the parents themselves, and slightly more frequently in the mother (14 cases) than in the fathers (11 cases). In 2 cases, both parents presented some functional disorder. 3 children were brought for consultation, after their fathers had been treated at our Center, while one mother (77) first brought the child and then came as a patient herself.

Two of these cases, already quoted, have shown instructively, how the neurotic or possibly even psychotic behaviour of a father or mother can affect the child, particularly if the absence of the healthier parent reduces emotional security even further : Kamal Kishore (77) not only lost the only masculine model in the family through his father's absence, but, during this vulnerable period, had to bear the strain of his mother's compulsive symptoms. Pradeep (78), through the absence of his mother, was delivered more helplessly to the unbalanced moods of his psychotic father.

In two earlier examples, that of Rehman (76) and Iqbal (71), we had seen that even the particular form of the neurosis can be shaped in concordance with the symptoms presented by a sick parent : both these sons of compulsive mothers also developed compulsive symptoms. Kamal Kishore (77) also, though his frequent urinating at first sight impressed one as a protest against his mother's compulsive washing, chose for this very protest a form which contained compulsive elements. In another case, which we shall have occasion to quote later, the manic-depressive fluctuations of the father, who was a psychotherapy patient at our Center, seemed to reflect themselves in an alternation of unruliness and compulsion in his little daughter (case 86), while the son of another of our patients seemed to take the father's hypochondriac withdrawal from his responsibilities as an excuse for neglecting his own school-work (case 93).

Advocates of biologically determined heredity would probably use such examples to prove their point of a genetic transmission of certain "reaction patterns". Against this, we can hold up cases amongst our adult patients, in which the compulsive habits

were not acquired from some close family-member, but suggested by the practices of some neighbour or mother-in-law ! Similarly, though we have seen some patients who, in their hysterical demonstrations, closely followed the model given by someone in the family, we could probably demonstrate an equal number who "copied" fits witnessed outside the family.

The development of a neurotic defence is not something that "just happens", as certain psychoanalysts like to maintain. Some choice and constructive activity seems to be required in building up a symptomatology that will not only suit the needs of the patient, but also convince his surroundings. In this process of construction, any "ready-made" material can be welcome, just as in building a new house one would not hesitate to make use of blocks of stone or tiles available from some ruin or, as a bird, in building his nest, will weave any easily obtainable material into it. By using a "ready-made" symptom, either by taking it over from the example of some other person or possibly by "fixing" the physical consequences of some illness or accident or merely some particular physical feature of an acute anxiety attack, one probably can save energy. Furthermore, any manifestation which has already been established in a certain environment as "sick" or "respectable" or as excusing from responsibility, because it is believed to be due to possession by evil spirits, is sure to allow a safe "investment" apt to be recognized by those whom one has to impress. Unconscious motivations and processes of this kind are just as likely to affect the choice of symptoms as any factor of biological heredity. How could one otherwise explain the fairly generalized "fashions" and "trends" which decide in each culture and in different periods of it, what neurotic symptoms are to have "currency value" ? We must admit the possibility that the play between revealing and concealing, though finally it may result in the rigidly fixed "iron curtain" of a fully developed neurotic defence, has its freedom at least in the beginnings of symptom formation, and that it is not rigidly and permanently tied down by the arrangement of certain molecules in the genes.

What, however, may have to be attributed to heredity, may be some general constitutional characteristics, perhaps consisting more in a general degree of vitality, a varying ability to react to the surroundings, to keep out what is harmful and to assimilate and transform what can nourish and sustain at any given stage of maturation. Even in this sense, "heredity" may not be all-powerful. No human being is entirely the product of his parents' union. The material body with all its functions, which certainly is transmitted by the physical processes of procreation, only provides the outer shell, some of the conditions for "realisation" for the living soul which has its origin beyond any mere material happenings. The Indian theories of "sanskara", of the cooperation of the soul-to-be-born in finding its parents, would even seem to turn biological notions of heredity completely upside down. According to them, one would have to suppose that it is not the parental protoplasm that shapes the child's constitution, but the inherent destiny of the child that chooses the parents. This theory, incidentally, may not even sound particularly strange and impossible to Westerners, provided that they have studied and appreciated the teachings of L. Szondi (25), who assumes

somewhat similar processes of a reversed heredity, *i.e.* the search by some quality or "drive" for a suitable incarnation. If "choice" independent of the rigid laws of biological genetics can be visualized even in this major issue, why then should it not play a role in the building up of neurotic symptoms?

This independence of a child's constitution from the parental "genetic material", is sometimes strikingly demonstrated by the birth of a child who is quite different from anyone else in the family. Biologists, of course, have their explanation ready by talking of "mutation". Instead of venturing on further theoretical hypotheses, it may be more to the point to present a concrete example of such disparity. The cases that were most impressive in this respect, were those of extremely sensitive children born into a family of more robust people. No doubt, many other combinations are possible and actually occur. The sensitive child in a robust family or, as we sometimes call it, "the gazelle in a herd of buffalos", however, is most likely to be misunderstood and mishandled without being able to stand up for himself, and therefore may develop neurotic reactions more easily than other types. 7 of the children in our neurotic group seemed to have been such "freaks" in their families. As the author has since seen examples of such "displaced children" even outside her psychiatric activity, *e.g.* in the families of rough mountain peasants, the problem deserves to be illustrated by a typical case-history :

- (79) *Veena*, a little Brahmin girl of 7, annoyed her parents by her "lack of understanding", her "talking off the point", her nervousness and stubbornness, her habit of occasionally biting her younger siblings and of grinding her teeth in sleep. She had been sensitive and easily scared since infancy, but, being the eldest child, not only of her parents, but amongst the group of 6 cousins in the joint family, she was expected to be tough and reasonable and to set a good example.

The father, employed in Government service, tended to have fits of temper, but was rather more patient and loving to *Veena* than her mother, who took more interest in private higher studies than in looking after her children. While she was pregnant with this first child, she suffered from chronic dysentery. After a normal delivery, the child was breastfed for 3 years, until the next sister was born. A brother followed, when *Veena* was aged 5.

As a small baby, the mother found her "dull and unresponsive". She started walking and talking late and was only fluent in speech at the age of 5. At about the same time, she stopped bedwetting. She is one of the children of whom the parents said : "She was always so quiet ; so no one bothered about her", which usually indicates a certain amount of early neglect. At the age of 3—5 years, she suffered from "enlarged liver".

As no one seemed to understand the child's sensitive and imaginative nature and her need for human warmth and closeness, the other children in the family teased

her by calling her "pagal". Though she would have liked to join them in their play, they would not accept her. Even her mother cursed her as "mad" and, in front of the child, wished that she should die. The father had a little more understanding, but was seldom at home. The person to whom the child seemed to be most attached, was her maternal grandmother. Though she was also rather robust and matter-of-fact, she at least had some natural motherly warmth, in which the child seemed to feel more secure than at home.

On examination, we found that the delicate, pretty little girl had very graceful movements, which at times suggested dancing-steps and gestures. We were told that she was very fond of music and dancing ; but apparently no one at home had taken any interest in developing or appreciating these talents, which were considered to be quite useless.

When left alone with the psychiatrist, she first was shy, but soon opened up and become inquisitive and affectionate. Building a kind of temple with bricks of various shapes and colours, she finally sat in the midst of this structure, cross-legged, graceful and solemn, like a little Devi. On the blackboard, she traced very delicate curved lines. When given pencil and paper, she drew a square and one isolated small circle in it. When we ventured a guess that this drawing perhaps symbolized her own loneliness, she produced a second drawing. This time, 2 small circles were enclosed in a square, while another circle was placed outside. She explained that mother and she should be together, while the younger sister was to be excluded. In a similar attempt at substituting her wishful imagination for hard reality, she maintained that she was the youngest child in the family.

Apparently, the little girl, starving for affection, found pleasure in the gentle touch of the doctor during physical examination. When she came for the second visit, she insisted on going to the room for physical examination and on repeating the whole procedure. When, apart from this, she was given an opportunity for affectionate contact, she was only too glad to snuggle down in the doctor's lap and even asked this "mother substitute" to sing a lullaby for her. Being accepted and appreciated by some one in all her fairy-like delicateness, seemed to be a quite unusual experience for her. When she was brought for her third and last visit, the accompanying grandmother, who was about to take her to her home in a neighbouring city, mentioned, almost reproachfully that the child now proclaimed at home : "The doctor at the Psychiatric Center loves me, and you people don't". It looked, as if our appreciation of the child's particular nature had at least stimulated some interest on the part of her relatives.

Though some of the features mentioned by the mother in her history of infancy first made one suspect a severe disturbance of the type of infantile autism, the rapidity and readiness with which the little girl opened up under a minimum of concern and affection, seemed to prove that there was nothing very abnormal

about her, but that she had just been "born into the wrong family". We tried to make clear to the parents that the child represented the type of the sensitive and imaginative potential artist, which, in certain ages of human history, would have been highly appreciated. Born into an epoch of increasing materialism and rationalism, and into a family without understanding for her particular gifts, the child naturally felt isolated, misunderstood and rejected.

In order to develop his or her potentialities, a child has to grow up amongst people who recognize them and who give them an open place in the light of their concern and understanding. If this necessary condition for growth is lacking, the natural gifts may atrophy, and the child may have to struggle hard in developing in a direction quite contrary to the natural inclinations, just as a left-hander, forced to use the right, will finally remain clumsy with either hand. While this provokes a sense of frustration, attempts at following the true destination may mean exposure to loneliness and therefore anxiety. School may at least offer some subjects that appeal to the imagination ; but such children may again be teased and tortured by more robust schoolmates, so that education too becomes an ordeal. If, furthermore, the parents are not much educated, the child may soon grow beyond any shelter which the home atmosphere could offer.

Perhaps it is a development of this type, which one of our adult schizophrenic patients, a brilliant young scholar, who had ventured far beyond what anyone in his family could understand, summed up in the following rather cryptic lines, when asked to sketch his self-portrait : "I am that intoxicated, yet still very theoretical persons whom there should be someone to recognize." Intoxicated ? Perhaps because he was not fed with what would have been healthy nourishment for his particular nature. Theoretical ? Because what was best in him, may have remained a mere theoretical potential, deprived of growth in the sunlight of someone's recognition.

Such observations are apt to make one realize the deepest meaning of psychotherapy : to give the patient a chance of unfolding and revealing himself in the light of a consciousness that excludes none of his potentialities, to provide him with a playground on which he can practice all his possibilities.

In previous chapters, we have characterized the role which heredity may have played in transmitting a certain degree of vitality or ability to survive, by giving figures for sibling mortality (Table IX). For the neurotic group, we find figures lower than in any previously discussed group, both for the number of families in which one or more children had died in infancy (31.5 per cent) and for the number of children who died amongst all siblings (15 per cent). Except for the group of infantilism, in which, however, the families are less complete than in groups containing older children, these percentages are the lowest ones amongst all groups. This again would support the assumption that, in families of neurotics, no great amount of biological heredity in the sense of genetic deterioration or even "letal factors" is involved, but that environmental

influences, including emotional instability of parents and other close relatives as a postnatal feature, may be more responsible for the deviations in development.

(10) *Number of Siblings and Position in Sibling-Row* (Tables X and XI, Graph VI).—In the families of the neurotic children, any number of siblings between 1 and 13 is represented, but with a definite maximum of families with 3 children. Through early death of 15 per cent of the children, the pyramid is somewhat reduced, the maximum number of siblings surviving in one family being 11, and the most frequent number 3 and 6.

The considerable portion of families with more than 3 children means a relatively low percentage of possible "special positions". Even this low value of 58.4 per cent, however, is not significantly exceeded by the actually occurring number of "special positions", which amounts to 65.4 per cent amongst the surviving children, *i.e.* 7 per cent or about 1/8 more than one would expect, if all children had been exposed to equal risks of becoming neurotic. We have, however, already seen earlier that "special positions" take a quite prominent place amongst the combinations of the congenital-organic groups with neurotic trouble. Amongst these cases, the excess-rate amounts to 19.1 per cent. We concluded from this figure, that children with congenital and organic handicaps have less chances of making the best of their limited capacities, if they are exposed in a unique position in the family. On the other hand, we also pointed out that these handicapped children lead a life more confined to the home and that, therefore, the main unsettling factors that can touch them are those that play within the family, while the children in whom neurosis is not superimposed on any organic or congenital defect, are less dependent on their parents and more exposed to influences outside the family circle.

The one position, however, which even in the "pure" group of neurosis seems to claim a disproportionately high number of victims, is that of the eldest or only child, both born and surviving. The rate for eldest and only children is almost twice as big (plus 82 per cent) as it would be, if these positions had not comported any particular risk of neurotic development. The figures for eldest sons and daughters who are not first born, and for youngest children, remain slightly behind the "maximum possible" rates. But one will have to consider that we neglected to calculate an absolutely specific rate for the position of first sons and first daughters, which do not occur in all families, and that in "young", still incomplete families, the position of the youngest may be a temporary one, when further children are to be expected.

Amongst the examples already quoted, we have presented some eldest children : Kamal Kishore (77) eldest child and only son ; Shobha, (74) eldest child and only daughter ; Uma Shankar (69) and Promod (70), both first born and only sons. Sohan (66), only child ; Tajwar (73) eldest of 3 children ; Veena (79), eldest child, not only of her parents, but of a whole group of cousins in the joint family.

While, in view of this selection already given, further examples are hardly necessary, one might again be interested in knowing, what particular symptoms such eldest children are likely to develop. Graph 4 sums up, not only the children who were first born, but also those who were eldest of their sex. Those children who remained the only ones in their families, are not counted in this connection.

If we assume roughly a proportion of 3 : 7 (according to Table X) between children who are the first of their sex and all other children in the group, we see that the main symptoms which exceed this ratio, *i.e.*, which can be supposed to be specifically represented amongst these eldest children are : hysterical manifestations and conversion for both girls and boys, neurotic development for girls and anxiety for boys. Completely missing as main features are compulsion and depression, while as accessory symptoms, compulsion plays a slightly more important role amongst the boys and depression amongst the girls. Hysterical manifestations of an accessory nature are also more frequent in the eldest girls. The cases in which we noted a multiplicity of symptoms are, with the exception of one, all amongst these eldest children. Consequently, we also find a representation beyond average of those symptoms (infantilism and spite), which only occurred in an accessory function. Cases which we considered as "borderline psychosis", do not occur more frequently in these eldest children than in the whole group.

The list is not very conclusive, and one has to assume that other factors, such as joint family, possibly parental attitude, number of siblings, might contribute to the shaping of symptoms. The relative lack of depressive reactions and compulsive patterns, and the predominance of multiple symptoms without, however, an abnormal rate of borderline states, would make one suppose that the child who is eldest, absolutely or of his sex, is used to a certain expansiveness and to excessive attention, as also the predominance of hysterical manifestations, usually calculated for an audience, would indicate. But it looks as if, at the same time, due to the well defined position, a certain sense of individual identity and limitation may have been acquired.

A history of an only child has been presented : Sohan (66). He is the only one who, right from the start, was meant to remain the only one. Of the two other "only children", one still had a chance of being followed by further siblings, while the other one's mother could not have any more children due to illness.

Of the 8 youngest children, we have already quoted the case of Samiun (75), youngest of 12. Another instructive example is that of a Baniya boy of 14, who was brought when he was almost on the point of psychotic disintegration. As Samiun (75) also is one of the "borderline psychosis" cases, it may be interesting to mention in this context that 4 of the youngest children, *i.e.*, 50 per cent, were counted amongst these borderline cases, while amongst the eldest boys and girls only 13.0 per cent approached psychotic disruption. The most frequent main symptom in these youngest children is anxiety.

- (80) *Vijay* was the last of 13 children of a rich business man from a village in U. P. Probably the family was a joint one ; but information is not quite certain. No mental illness was known of amongst the relatives. Of the 12 siblings, two had died in infancy. The remaining ones were healthy. Whereas the father had never shown much concern for the family, the mother had watched anxiously over the development of her children. While the elder ones were able to escape from this overprotectiveness, whenever the mother had to concentrate on the next younger baby, *Vijay*, the youngest, born when the mother was already aged 37, remained in her clinging grip, even when the physical signs of puberty had already started developing.

After normal delivery, the boy was breastfed for 2 years. He was an active and playful child, pampered by the whole family. At the age of 6, he started school. He had reached up to 6th class, when, at the age of 12, he fell sick with influenza. Though already at 9 he had suffered from typhoid, this minor illness 3 years later seemed to impress him as something very unusual and dangerous. One of the reasons for this anxiety, which took on the form of extreme fear of dying, may have been that, while at the age of 9 he had been under the care of his mother at home, this second illness overtook him, when he was staying with one of his elder brothers. When, shortly after recovering from this attack of "flu", the boy returned home, he had developed some very childish behaviour : He would steal anything he could take hold of and pinch and hit other family members. He wanted to hold his mother's breasts and suck them. He seemed to have lost all sense of shame and masturbated quite openly. He frequently went into fits of extreme anxiety, in which he feared that some thieves might come or that he might die. His dreams also were full of fearful scenes. At times he would remain quiet and depressed and complain of palpitations. Even when he was not in any acute fit of anxiety, he avoided being alone and often clung to his father like a small child. He had given up going to school, taking part in any games and even refused to take his bath. From time to time, when in a more reasonable and relaxed mood, he would feel sorry for his strange behaviour. By the time the boy was brought to us, 2 years after the first symptoms had been noted, he had already been presented to various doctors, even at a mental hospital. One doctor had not only advised, but also performed tonsillectomy. On the other hand, the boy had also been taken to a number of pilgrimage places. One "Baba" had taught him some mantras, which he kept repeating compulsively. As one particular mantra was supposed to last for 40 days, he would always get more anxious and excited, when the magic power of this compulsive performance was exhausted before he could get a new formula. It may be interesting to note, how a kind of "compulsive symptom" had been imposed, this time not by the example of a relative, but in an attempt at "treatment" by some one outside the family !

On examination, we found a very rapid pulse, the stomach bloated with air, and signs of general nervousness. The boy was restless and tense, biting his nails,

picking his nose and constantly trying to cling to one of his relatives, preferably to his father. His anxiety increased, when he was supposed to lie down for physical examination. He again and again tried to run away and, when kept back by the doctor, went into babyish temper-tantrums. Once, when a female staff-member tried to keep him back, he snatched at her breasts and pressed them. His few drawings either betrayed complete confusion and dissolution or then a desperate attempt at keeping things together by rigid squares with repetitions of his own name, that of "Ram" and some of his mantras.

The boy's behaviour, which was met by the relatives either with helpless tolerance or then with anxiety or ineffective outbursts of anger, suggested his being delivered defencelessly to the two forces of sex and aggression, which were rising in him during this period of puberty. Possibly, a weakening of resistance during the febrile illness had made him more aware of his lack of inner control. Possibly, however, he had already felt insecure and guilty before this illness, which happened at a time when he was separated from the mother, and his fear of dying may have represented a crystallization of a previously existing anxiety or possibly even the apprehension of deserved punishment.

While first, when we asked him about any possible cause for anger, he only started biting his nails and automatically reciting some prayers and mantras, he later, during a second visit, admitted that he was angry with himself, because something inside him did not obey him. By this, he very probably meant his lack of control over his sexual instincts. When, realizing that amongst the relatives no one was able to present a firm resistance, the psychiatrist gave him a chance for "letting off steam" in a little wrestling-match, in which he was to experience someone stronger than him, he fought quite lustily. After this, the doctor held out her hand to indicate that she was ready to absorb his anger. He made the motion of spitting into her palm and then stated, somewhat more calmly, that now it had "all come out". One will remember that Iqbal (71), whose symptoms bear some resemblance, had also tried, on one hand, to tie down his aggressive tendencies by compulsive practices, while, on the other hand, he attempted to get rid of his internal "badness" by spitting.

In Vijay, the contradictory tendencies had not been so safely tied down in the compromise of compulsive practices. One still could note considerable open ambivalence : He would not stay in the consulting-room, while supposed to be there ; but when we wanted to talk to his father alone, he sneaked in and insisted on remaining there. He, on one hand, felt attracted to women, showing an interest in their anatomy, which doubtlessly betrayed some adult lustfulness, while, at the same time, the baby in him seemed to look for the mother's milk. This attraction towards women, in itself a contrast between babyish clinging and male aggressiveness, was again counteracted by his attempts to avoid women and to seek protection by clinging to the father, in whose lap he would snuggle up like a small baby.

One felt that this pampered youngest child, who had probably never had to bear any frustration and obstacle, and who therefore had never had a chance of realizing his limits and powers of resistance, had been defeated at the moment when forces that had to be opposed rose up within him. In dealing with them, he not only would have had to display the power for resisting and containing, but in whatever way he was to face them, some frustration had to be born : either renouncing the satisfaction of his sexual lust and aggressive tendencies or then giving up the ideal image of being "a good boy" and risking the wrath of the Gods. Frustration, however, always puts limits, teaches one the "end" and therefore may be a symbol of annihilation and death.

The fact that 10 other children, 5 of them also boys, had grown up normally beyond adolescence within the same family, makes it very likely that Vijay's position as the youngest was a decisive factor in the genesis of his neurotic or almost psychotic symptoms. It looks, as if the necessity of being pushed out of the mother's lap to make room for a younger sibling represented a wholesome stimulus for individual emancipation and limitation and, if the mother is overanxious and clinging, perhaps even salvation from being swallowed up by her. The youngest child is denied this encouragement, unless the mother is reasonable enough to plan his real welfare or unless the child is strong enough to tear himself away and to venture the journey out into the world on his own.

If special positions amongst the siblings seem to have so much importance in contributing to neurotic reactions, one may ask, what caused the distortion in the 34.6 per cent of children who occupied no unique place in their families. We have already mentioned that each child has got his individual needs, and that a parental attitude which may suit some of the children in the family, may be harmful to another one. Furthermore, influences outside the home, experiences of illness etc. may also play their role. Apart from them, however, particular constellations in the sibling group itself may affect even children who are born in an inconspicuous position.

A situation, for instance, which can be very trying, is that of the second daughter followed by a son. While the first child usually is accepted, even if it is a girl, a second disappointment by a mere daughter usually weighs more heavily. If, further more, the third child is a boy, this second girl, who has neither the privilege of being the eldest nor the luck of being a boy, is easily neglected. A similar lack of attention or even reproaches and unfavourable comparisons, can be the lot of any child who is followed by another one who draws the limelight by any special merit or ability. Finally, in very big families, a child with little capacity for self-assertion, may succeed less than his smarter siblings in securing his just share of parental concern and attention.

A theme frequently stressed as a possible source of neurotic conflict, is that of sibling rivalry. Amongst our neurotic children, we noted 14, *i.e.* slightly more than

25 per cent, in whom sibling rivalry seemed to be an important factor. Only 2 of them have been presented up to now : Shobha (74), who was displaced from the parents' favour by a series of younger brothers, and Veena (79), who was rejected because of her different nature. While in these two little girls other factors, in particular their position as the eldest in the family, may have been more decisive, resentment against the siblings and ambition to keep up with them seem to have been the main factors in the two following cases : one again an example of an eldest child pushed from his place by the next younger one, the other one the last of a lengthy series of girls followed by a brother in a big family :

- (81) *Anil*, a 5 year old Kshatriya boy, is one of the stammerers who, as we mentioned earlier, are all first born sons. A paternal great aunt was known to have been mentally ill. The father, a Government servant, was quiet and reserved. He showed little interest in his family and tended to get nervous and impatient with his son. The mother also was of irritable temper. She was sociable and liked to go out ; she resented being kept back by a mother's duties. In her perfectionism, she got annoyed, whenever the children upset her spotless order. She often complained of some minor physical trouble. Anil was born, when the mother was aged 21. He was breastfed for $1\frac{1}{2}$ years. During the first few days of his life, however, he had to be spoonfed, as he would not suck the mother's breasts. When aged one month, he had to spend some time in hospital with diphtheria. We do not know, whether during this period the breastfeeding was continued and whether the illness caused any difficulty in sucking or swallowing. He learned to walk at 15 months. When he started talking, before he had finished his second year, he showed no sign of stammering. Even when, at the age of $2\frac{1}{2}$, he went through a severe and long lasting attack of whooping cough, his speech still remained clear. Already at 3, he was sent to nursery-schools. This early start seems to correspond to what our other stammerer, Promod (70) remembered about his upbringing. But, while Promod had himself insisted on going to school so soon, Anil resented his being driven from the warm nest, all the more, as he had to be ready for his school-bus already at 5.30 a.m. ! At the age of 5, he was sent to the first class of a primary school, which kept him away from home and busy from 07.30 a.m. to 3 p.m. every day. No wonder, that the small and delicate boy developed no interest in learning !

According to the mother, even this premature start of formal education did not produce any obvious symptoms. Only when, at the age of 4, he was dethroned from his unique position by a younger brother, he started to stammer. He became stubborn and at times very babyish in his behaviour. He developed various "food-fads" and messy table manners. While he had acquired independent toilet habits already at the age of 2, he now urinated in odd places. In sleep, one could hear him grinding his teeth. With outsiders, he would be extremely shy and hide in his mother's saree. As long as the younger brother was a very small baby, Anil did not show much jealousy. But during the last few months

before first consultation, he had shown his resentment quite openly. He would at times ask the mother to go away and to take the little brother with her. At other times, he seemed to hope that he could gain the mother's favour by imitating the baby's behaviour. When the mother scolded him for these regressive demonstrations, he would threaten that he would go away "to Bhagwan". While the mother showed her annoyance openly, the father tried to bribe the boy into obedience by false promises.

As to the stammering, the mother supposed that the boy had copied this symptom from one of his little friends. After this boy had visited him, at the time when he was 3, Anil had, at times, imitated his way of speaking as a joke. Later, this "bit of material" came in handy, when he had to build up his own neurotic structure. As in the previous case, the symptom seems to indicate a conflict between one part that wants to hurry ahead, while another part pulls back. While, in the robust Promod (70), the ambitious tendencies seemed to be part of himself, they appear to have been forced on the delicate and sensitive Anil by his ambitious parents. Making quick progress, seems to have been the only way for gaining appreciation which he had known up to the little brother's birth. When suddenly he had to witness that this little rival could steal the mother's attention by his very helplessness, he seems to have been in dilemma between continuing in the previous line of quick advancement and regressing to the easy, secure life of a baby.

This difference between the two cases with the same symptom, demonstrates in an instructive manner that stammering can be the result of two main combinations of factors. We can have, as in Promod (70), a relatively robust child, who identifies with the tendency to hurry on and who resents any influence from the outside or from within himself that tries to check this speed ; on the other hand, we get asthenic patients, who might like to develop slowly, but who are forced, by their surroundings, into an unbecoming hurry. The outcome is the same ; a struggle between two different speeds, a tendency to grow up quickly and some other, less mature part that wants to keep back.

To come back to Anil's case : the child looked delicate and thin, and the dark rings round his eyes seemed to indicate exhaustion. Neurological examination could not quite exclude slight brain damage, possibly due to one of the infectious illnesses. He was anxious, shy and fidgety and was obviously terrified by the physical examination. The stammering was not very obvious ; but he spoke very little and in a very small, timid voice. When we observed him during free play in the children's room he was more relaxed. What he built with the bricks, all rather perilously high structures with an insufficient base, reminded one of his precipitated development that had not been sustained by sufficient motherly warmth and shelter.

While absorbed in play, he often pursed his mouth and performed sucking movements.

This would support the Freudian theory of "oral frustration", which indeed seems to be an important feature in stammerers. We mentioned earlier that stammerers seem to draw or suck in the air while speaking, instead of using the stream of expiration for phonation. This seems to indicate, apart from the tendencies towards inflation, which we already suggested, a basic conflict between "giving" and "taking". In early infancy, the mouth serves exclusively for "taking". Even crying is in the service of this satisfaction. Speaking, however, as the Hindi combination "bol dena" indicates, represents a gesture of "giving". In the stammerer, the unsatisfied wish for taking, which often impresses one as a regular greed, seems to interfere with the need for giving. One wonders, whether modern psychoanalytical theories only have rediscovered what was already intuitively known in ancient times, if one discovers in a Sanskrit dictionary (26) that the same word "cucuka" signified both "stammering" and "nipple" !

- (82) *Kamal Kaur*, an 11½ year old Sikh girl, is one of the children included in the group with delinquent features. As, however, her case is a very typical example for sibling rivalry within a bigger family, it is to be presented already here :

She was brought to the Center by her parents, because ever since the age of 5 to 6 she had puzzled them by running away and stealing. They estimated that she must have left home at least 100 times, often staying out even during the night. Wrapped in her big woollen shawl, she would settle down near some temple or on the doorstep or verandah of some house. Once she managed to roam about for 11 days. Before leaving home, she would steal some food or money. During her escapades, she would either try to earn something by doing little errands or some other work or, in case of need, steal from some shop. The parents had tried to prevent her from leaving the house by keeping her tied to the bed.

On exploring the family setting, we found that the father, aged already 55, owner of a rickshaw business, was suffering from high blood-pressure. He called himself a kind, loving father. But, during the interview, we noted that he showed the emotional lability typical for chronic alcoholics. He admitted later that he occasionally got drunk and then had fits of temper. He showed some understanding for the child's illness ; but it was very doubtful, whether she could find any constant support and security with him. The mother was a short-tempered, strict woman. She herself made no secret of the fact that she had never cared for the child, and Kamal Kaur herself was quite aware of her lack of interest and affection.

The mother's rejecting attitude finds its explanation, when we consider the girl's position amongst her siblings : she was the 10th of 13 children. Of the 9 elder siblings, only one was a brother, aged 27. So she was the 9th daughter and the 7th in an uninterrupted series of girls. When she was aged 2½, a second boy was born, followed later by another sister and a youngest brother, who was aged 4, when we got to know the family. These 2 boys, particularly the one just younger

to her, quite obviously had taken away all the mother's affection. We were able to observe, how this little brother, aged 9, tried to sneak into the play-room and to steal even the therapist's attention away from his sister. Added to the rivalry of this favourite of the mother, was perhaps also the fact that Kamal Kaur was dark coloured and disfigured by an ugly scar on her forehead, probably the result of some beating. No one in the family seemed to care for her.

When we first saw the girl, she was shy, sullen, withdrawn, wrapping herself completely into her big knitted shawl, which seemed to have become a kind of protective shell to her. During the first interview, she hardly looked up and did not talk. But she relaxed, curling up on the female doctor's lap, from time to time, however, suddenly tightening up again. When she was supposed to leave, she slumped down on the floor near the doctor's knees and refused to get up. Having found a place, where she could enjoy some security and affection, she obviously did not feel like returning to her loveless home. During the next 3 interviews, she was more communicative. But even then, she was only accessible to indirect methods,—drawing pictures, playing with plasticine—by which we were gradually able to guess her situation : that of a child who, instead of being mothered and cared for, not only lost this affection early, on birth of a younger brother, but, in addition, had to take up mothering functions for these very siblings who had become her rivals.

Even the little help we were able to give during 4 interviews, seems to have effected a change. The parents began to grasp, where the problem might lie, and when coming for the last consultation, the little girl, now much more relaxed, told us with some satisfaction that now she was no longer being tied to her bed at night.

This case reminds one somewhat of Shobha (74), the Hindu girl from a big family. In both girls, one can note a certain element of spite, which could be formulated like this : "Alright, if you no longer allow me to be a child, then I *am* going to be grown up. You will see..." But while Shobha, so-to-speak, transforms her spite into the socially acceptable attitude of being proud of her functions of a housewife and mother, Kamal Kaur seeks her independence in roaming about and stealing. This antisocial behaviour not only gives her some satisfaction, but is at the same time likely to "punish" her parents. If one remembers, how easily Shobha's proud, grown-up facade crumbled and gave place to mischief and a wish to punish the mother by her negligence, one will realize that the fundamental attitude of both girls had something in common.

(11) *Age of the Mother at Birth of the Child* (Table XII).—In the group of neurotic children, the percentage of mothers who gave birth to the child before the age of 20, though slightly smaller than the average for all children, is, with 20.9 per cent, highest

of all functional groups. The share of "old mothers" is slightly beyond the average figure, but considerably lower than that for the group of psychotic adolescents.

Most of the "young" mothers were aged 18 or 19, and their youthfulness hardly seems to have affected the child's development. The one case, in which the mother was below the age of 16, when she gave birth to the child, may possibly reflect a lack of emotional maturity in the mother. Furthermore, the child's physical weakness and her susceptibility to infectious diseases, which played a great role in increasing her anxiety, may indicate that the mother had not been quite ready biologically to give birth to a child with full vitality.

- (83) *Premi's* father, a Christian, was a chaprassi with a miserable salary. One year after his marriage with a very young girl, *Premi* was born. During the last months of the pregnancy, the mother was ill, possibly with tuberculosis. After the delivery, both the mother and the very weak baby, suffered from fever. After having learned to walk already at the age of 10 months, the child suffered a setback in her development through chronic dysentery, probably a dystrophic, state. Though she learned to speak at the age of 18 months, she was only fit for walking again at the age of 2. At 3, she had typhoid, and 6 months before we examined her, she had gone through chicken-pox and pneumonia. In between these major illnesses, she frequently suffered from colds and fevers. After her 2 more girls were born, one 3, one 6 years younger than *Premi*.

The parents brought her for consultation at the age of 8, because she complained of weakness and giddiness, tiredness and difficulty in breathing. The slightest exertion caused palpitations, and in any situation of emotional tension, for instance when scolded, she would become breathless. She lacked appetite and occasionally vomited bile. At night, she startled up from sleep completely scared. At times she would sit with closed eyes, lost in phantasy. The small, thin, delicate girl looked serious, depressed and anxious. On physical examination, apart from general weakness and malnutrition and some glands on the neck, we found discrete signs of some brain-damage.

In the play-room, she first was shy, but later she relaxed and sought physical contact with the doctor. Asked about her startling up at night, she told us that she was scared by dreams in which people threatened to kill her, or in which a big black man tried to catch her.

According to the parents, some of her anxiety was due to the fact that, during the first 4-5 years of her life, the little girl had lived near a "burning ghat", where she had often seen the dead bodies being burned. Recently, she had also heard of some deaths in the neighbourhood and, above all, her own grandfather had died. In addition to watching the Hindu funeral ceremonies at the burning ghat, she had had her ears filled by some Muslim neighbours with stories of ghosts. So

the theme of death and the world beyond had touched this sensitive girl early, not only by her witnessing its ravages in the outside world, but probably because her own little flame of vitality was so poor that it risked to be blown out by any illness.

Instead of granting the weak and sensitive child shelter and at least a chance of growing up according to her own speed, the poor parents only had the one ambition of giving her an English education ! When she was first sent to school at $6\frac{1}{2}$, she had to give up the attempt, as she was too weak. Shortly before we saw her, she had again been enrolled at an English school. Again she had to stop, because her health was so poor and because, in addition, she got scared on seeing some children being beaten. Even her short experience at this school, however, had apparently sufficed to create in her a terror of failure and punishment, which rendered her tense and anxious, whenever she had to approach any task.

All we could do during the one interview, apart from giving advice to the immature young mother, was to try to create a little self-confidence in the child by making her meet some of the threatening "ghosts" in the harmless form of drawings or plasticine figures, in which they had no power to hurt her, but on the other hand, could be mastered and even destroyed by her. After the symbolic execution of a big black man, drawn on a piece of paper according to her instructions, she seemed to be a little less anxious and was ready to turn to some constructive play. Continuation of this play-therapy, of course associated with suitable physical care, might have promised a more permanent success. The child, however, was not brought back after one interview.

A child of a relatively old mother, aged 37 at his birth, has already been demonstrated in Vijay (80). He, as well as the two other sons of "old mothers", are youngest children at the end of a long sibling row. One other boy also showed anxiety as his main symptom, while the third one had developed delinquent tendencies.

(12) *Complications of Pregnancy and Delivery* (Table XIII).—Both, the figures for disturbed pregnancies and complicated deliveries, with 3.7 per cent and 11.1 per cent respectively, are far below the average for our total material. There is therefore no need for any special discussion of these features.

(13) *The Period of Breastfeeding*.—If, in consideration of the figures provided by the Department of Gynaecology and Obstetrics of Lucknow Medical College, only breastfeeding beyond the age of 2 is taken to be extraordinary, the small number of children in the neurotic group, who correspond to this definition, with 11.1 per cent (Table XIV), can hardly be regarded as significant. One may, however, remember that amongst the children whose neurotic manifestations were superimposed on some disorder of congenital or organic type, the ratio, with 17.1 per cent, is higher. Again we took this as a sign that a mentally handicapped child may put up less resistance

against a mother's clinging and that, on the other hand, a mother may hope to derive special merit and perhaps to atone for some guilt-feelings by this sign of maternal devotion. One must not forget, however, that one of the essential conditions for continuing breastfeeding over a long time is that no new pregnancy intervenes. Some women keep on breastfeeding in the hope that lactation will prevent conception. This "contraceptive method", however, is by no means safe. In a group in which big families are so frequent and youngest children relatively rare, as amongst our neurotic children, one therefore has to assume that the period of breastfeeding was not always a function of the mother's willingness, but more often of the interval between pregnancies.

Of the 6 neurotic children who were breastfed beyond the age of 2 years, we have already mentioned Uma Shankar (69) and Veena (79). Another instructive case, which at the same time demonstrates a clinging mother, is the following :

- (84) *Motilal* was the eldest and only surviving son of a Baniya businessman, living in joint family in a small town of U. P. His father suffered from asthma. He was irritable and lost his temper, particularly on our patient. The mother called herself "weak-hearted". She got easily upset and hovered over her children, in particular this only son, with a clinging, overprotective anxiety. Shortly after marriage, she had gone through a phase of mental confusion, probably some type of psychosis. A first son died of small-pox at the age of 5. *Motilal's* birth, at the time when the mother was aged 19, was followed by an abortion. A next child, a girl, died at the age of 2, while 4 further daughters, the youngest one only 8 months old, were living, when we got to know the family.

Motilal, who for a long time remained the only surviving child, was breastfed up to the age of 4. He started walking at 15 months, talking at the age of $1\frac{1}{2}$ to 2 years. All his wishes were always fulfilled. Except for chicken-pox at the age of 8 and typhoid at the age of 11, his development was uneventful up to the age of $14\frac{1}{2}$. Though always delicate and pampered, he remained simple and unassuming. He was, however, of somewhat suspicious nature and lacked self-confidence. In school, where he had passed his High School exam at the age of $14\frac{1}{2}$, he was generally respected for his fine character. It seems, however, that, at the approach of puberty, he disapproved of the loose talk and behaviour of some of his class-fellows. When some of his best friends moved to a college in a bigger city, while he, as the only son, was not allowed to leave the mother's protection, he preferred private studies at home to continuing amongst his rougher and less scrupulous comrades. Shortly before we saw him, he had, after passing Intermediate I, at the end of one year's private study, tried to join college again. He was, however, disappointed about not getting an opportunity for the subjects of his interest and became anxious amongst the other boys. A further oppressive factor, which curbed his keenness for studies, was the prospect of having to join his father's business even after successful higher studies.

At the time when the boy was brought to us, almost 16 years old, he was going through a second phase of intensive anxiety. A first, similar, but less pronounced one had been noted one year before, when he had to decide about his private studies. The boy went into fits of weeping, he felt depressed, had lost sleep and appetite and often complained of palpitations, a choking sensation in his throat, some "pinching" in his chest, weakness in his limbs and heat rising in his body. These typical signs of anxiety, some of which we already find very accurately described by Arjuna before he has to go into the battle of Kurukshetra (See *Srimad Bhagavad Gita* (27)), usually grew worse in the late afternoon or towards evening.

This is an observation which many of our "anxiety patients" reported. It probably has many implications. The most obvious one seems to be fear of approaching darkness. One of our adult patients, who had grown up in a village, linked it up with memories of being strictly forbidden by his overanxious mother to remain outside the house after sunset. This fear of darkness and all the uncanny ghosts and evil powers that move about in the realm of night, however, only seems to be the symbolic expression of a much more general and deep-seated anxiety. If a person, for the confirmation of his existence, has to rely on the outward world, which, so-to-speak, has to keep moulded in its frame a shapeless mass with no firmness of its own, if, unable to illuminate his existence by the light of his own consciousness, he depends on living within some one else's recognition, then the blotting out of the outward world on its being plunged into the darkness of night, means annihilation. This is terrifying, unless one can still, like the small child run home and hide in the mother's saree or cuddle up beside her in bed. While this may be possible, as long as the mother is seen as a mother only, the adolescent who begins to experience her as a woman, to whom his body may react, will be thrown into dilemma : his very refuge and shelter has become a source of threat. He either must give it up or then renounce further growth.

In our young patient, whose case somewhat reminds one of Vijay (80), a boy from the same caste, ambivalence with regard to his clinging mother was very obvious. On one hand, he resented her behaviour, and one could observe, how her anxiety increased his own ; on the other hand he was afraid of being without her. Even while we were examining the boy, she would come running into the consulting room, forcing some grapes on him by pushing them into his mouth. Whenever she spoke of her son, a sweetish, rapturous smile came over her face. Later, when we had prescribed some badly needed tranquilizer, which was supposed to put the boy to rest most of the time, she obviously resented his sleeping as, while not awake, he was out of contact with her. One actually wondered whether, far from finding an essential support in this once psychotic mother, the boy had not perhaps been used right from his birth to confirm *her* shaky existence ! At any rate, at the critical age of approaching manhood, this symbiosis had become a threat to the boy, while the mother, apparently

quite ignorant of the obvious erotic component she had mixed into this relationship, still tried to cling to him desperately.

In situations of this kind, the only solution is often that one of the two partners in the symbiotic relationship becomes ill, thus justifying the continued clinging, while the other partner can cast a veil of meritorious charity and self-sacrifice over a relationship that really hides weakness and distorted emotions. In dealing with cases of this kind, one often sees that, in the same measure in which the manifestly sick partner develops into a being in his own right, the hitherto "protecting" partner may start to show signs of anxiety and mental breakdown. In some of our adult patients, in whom anxiety or one of its disguises seemed to have arisen without any obvious outward provocation, we at times suspected that, through the natural growth of, for instance, a marriage partner, into independent, responsible existence, a hitherto symbiotically clinging partner may have been deprived of his or her support and thrown back on the insufficiently developed own resources.

One hardly wonders, if this family of our patient Motilal, though first extremely anxious about getting the best of treatments, lost interest in our efforts, when the mother realized that our aim was to help the boy to grow into a man !

While, thus, prolonged breastfeeding may be a first manifestation of an unhealthy mother-child relationship, it may be interesting to state, that the only two children in the neurotic group, one a boy, one a girl, who, owing to some illness of the mother, had not been breastfed at all, also threatened to go into psychosis at adolescent age. Both had a rather hostile and resentful attitude against their mothers, the girl very openly, the boy more in the disguise of jealousy of his younger brother.

(14) *Toilet Training*.—While some kind of disturbance of excretory functions, e.g., frequent urinating in Kamal Kishore (77) and urinating in odd places in Anil (81) formed part of the neurotic syndrome in 6 cases, the only child who was brought explicitly because of bedwetting, is the one Anglo-Indian boy in this group.

If the statistics of Delhi Child Guidance Clinic indicate bedwetting as the principal symptom in quite a number of cases, one wonders, whether the population of the big capital has already assumed more Western standards, or whether the children sent for consultation because of enuresis were perhaps amongst those referred by hospitals, where the nurses might have taken a less kindly view of such habits than the children's own relatives.

The wide tolerance which even educated Indian families still seem to have with regard to lack of toilet training, was once demonstrated to the author very instructively by the following little episode : A Brahmin girl, aged about 20, had been an in-patient

"Since this Chapter was written, I have myself had occasion to do child guidance work in the more emancipated setting of New Delhi since July 1965. Here, 18% of our small patients presented the symptom of bedwetting. One will, however, have to note that nearly all these children were referred to us through a children's hospital. Many of the parents appear to consider bedwetting as a purely physical disturbance and therefore consult general practitioners and paediatric clinics rather than a psychiatrist."

at our Center with a severe schizophrenic psychosis, for a long time. At the approach of some festival, her uncle, a highly educated man in a prominent position, wanted to give his niece the pleasure of spending the festive days with his family. When we warned him that the girl, though a lavatory was attached to her room, had taken to the habit of urinating on the floor just outside her bed at night, the uncle answered : "That does not matter. After all, she is our child !"

It looks, as if amongst Muslims, where defilement by even the slightest trace of urine makes a person unfit for offering his "namaz", tolerance for urinary incontinence were less large than amongst the Hindus, who, on the other hand, attach more "taboo-value" to the faecal excrements. While compulsive features in Hindu patients were often concerned with faecal matter, we have seen and heard about compulsive Muslims, who would not let anyone sit on their beds for fear that some drop of urine might contaminate them. On the other hand, we have observed that, in Muslim patients, the complaint about "some drops of urine escaping without control", can serve as a superficial excuse from fulfilling the prayer ritual, if they try to avoid facing deeper obstacles against paying their respects to Allah, e.g. some doubt about his justice or a grudge against his lack of attention to their needs.

To satisfy those who, having taken their psychological training from Western text-books, expect future child guidance clinics to be the meeting-place of young bed-wetters and thumb-suckers, we shall give the case-history of the one boy who was brought for consultation because of enuresis, though he is not a typical Indian child. Possibly, however the pattern of this emancipated Anglo-Indian mother may soon find imitation amongst some of the more educated Indian women :

- (85) *Kenneth*, a boy of 8, was the elder of 2 sons of an engine-driver and a school-teacher, both of Anglo-Indian origin. The father was described as bad-tempered. During the rare occasions on which he was at home, he often beat the children. The mother impressed us as authoritarian and emotionally cold. She not only continued her work as a teacher in an English school, though she had 2 children of her own and no financial worries, but, in addition to the teaching, even at the age of 41, still studied for higher degrees !

Kenneth was breastfed for a few months. Already when he was 5 months old, the mother put great stress on his acquiring clean habits. The boy, however, only stopped bedwetting at the age of almost 3 years. He had learned to walk at 15 months and was speaking fluently at the age of 3. Just at about that age, Kenneth was displaced in the mother's concern and attention by the birth of a younger brother, who subsequently developed more quickly and smartly than the elder child and who, quite obviously, stole the limelight in every respect. While Kenneth had to be nursed through a succession of illnesses : chicken-pox, measles, whooping-cough, jaundice, abdominal colics, the younger brother remained much healthier. Already at the age of 4, the boy was taken to school by his mother, less for his own benefit than because this seemed to be a convenient way of looking after him while she was teaching. The mother was very intent on representing matters, as if the

boy himself had been so keen on starting his studies early. But she had to admit that, last year, he had only been promoted with difficulty. At the age of 8, he was in 5th class, had to start his lessons at 07.00 a.m. and was hardly given any time for play.

The boy was brought to the Center shortly after he had shown reluctance about returning to school after his Christmas holidays. While already for the past one year he had shown some fear of darkness and an aversion against taking his bath, what really alarmed the parents into seeking help, was his bedwetting, which had started when the holidays drew to their end. At the same time, he had also been noted biting his nails and going into absent-minded dreaminess.

At first sight, the little boy, dressed smartly in flannel pants, shirt, tie and school-blazer, looked quite healthy and well-built. One could, however, see that his younger brother was not only about to outshine him by his sociable and pleasant manners, but also to overtake him by his physical development.

On physical examination, we found signs of some heart-defect, which seemed to correspond to his complaints of breathlessness after exertion. Some pain in his joints made one wonder, whether the heart had been attacked by some rheumatic fever. Nervousness and tension were betrayed by the clammy, damp palms and the bitten finger-nails.

While the boy first remained shy and withdrawn, he soon relaxed and became quite chatty, when he found our play-room less forbidding than school, and possibly also than home. His childish talk and play taught us quite a bit about his problems. He explained that he had been reluctant to go back to school, because, being the youngest and smallest in his class, he was being bullied by other boys. This feeling of being persecuted defencelessly, apparently found expression in his dreams about "wild animals eating rabbits" and "witches turning people into rabbits and rabbits into trees". When asked, what animal he would like to be, if he had the choice, he again mentioned a rabbit, who would dance in the moonlight and eat carrots. But he added that rabbits have many enemies, and that their only defence is to run fast. One sees that the child's phantasy world had been shaped far more by Western books for children, like Beatrix Potter's "Peter Rabbit", than by any Indian tradition.

When asked about the age at which the younger brother had been made to start studies, he mentioned 3 years and then added, with an amusing mixture of admiration and contempt, that his mother had been studying "ever since she was a baby". As one of his greatest wishes, he expressed that he would like to know "magic" so that he could turn his teacher (perhaps also his mother !) into something else, if she did not let him play.

The little boy, who quite obviously, if he had been left to himself, would have happily led a dreamy life in a magic fairy-land, had too soon been torn out into a cruel and demanding world. As probably he was in tension all day, with blood-vessels cramped up,—as his cold, damp hands indicated,—the only chance he got for relaxing in a child's world, was at night. But even then, his dreams were invaded by fear. Possibly some circulatory weakness may have contributed to an irregularity of kidney function. Even without any particular physical cause, however, the bedwetting would have been quite plausible as a sign of regression and relaxation in a child who had been driven far beyond his real level of maturity. The parents obeyed our instructions about further physical investigations, but remained impervious to any attempt at opening their understanding for the child's real needs.

This case somewhat reminds one of Anil (81), who also, though delicate and often sick, had been sent to school too early, and who reacted to the birth of his younger brother not only with stammering, but also with urinating in odd places. In both children, the urinary symptom seems to express a kind of protest against strict cultural demands imposed too early.

A symptom of protest, however, only fulfills its purpose, if it hits the "enemy" on a vulnerable point. The tolerance of most Indian mothers in matters of toilet training would render enuresis futile and ineffective as an expression of protest. Only a mother with a certain Western emancipation is likely to be impressed by it. In the 2 cases mentioned, the mothers had shed the traditional Indian pattern. They had their main field of interest outside the family and seemed to subordinate their children's true needs to their own convenience and ambition.

As far as our experience goes, the only type of traditional Indian mother who can be upset by a child's lack of cleanliness in his excretory functions, is the one suffering from compulsive symptoms. Kamal Kishore's (77) frequent urinating had its necessary complement in his mother's compulsive washing. Amongst our adult compulsive patients, we have seen women who abhorred anything that had to do with their children's excretions ; and one compulsive mother told us that one of her small girls, as if to spite her, had developed the habit of depositing her faeces in odd corners of the house.

Again we see that a neurotic symptom does not exist in a vacuum, but that it has its close connection either with what will be accepted by society or, on the contrary, if any spite and protest is involved, with what is likely to have "nuisance value" for the surroundings !

(15) *Early Neglect and Separation.*—In only 6 out of the 54 cases with neurotic features we either knew about a period of early separation or had reason to suspect a form of early neglect. One of them is Veena (79). In one case, we had a very detailed

history, as the little girl's father was undergoing prolonged psychotherapy at our Center, and the mother frequently came to see the social worker in connection with the treatment of her husband and the child. These parents who had both reached a point in their lives, at which they could not only recognize, but also admit their mistakes, gave a ruthlessly sincere picture of the severe neglect to which their little daughter had been subjected. As, amongst other symptoms, the child, already at the age of 6, had taken to stealing money, she also figures in our group of delinquent children.

- (86) *Rita's* father, an administrative officer, had already shown signs of some psychosomatic trouble in his childhood, which stood under the shadow of early death of her father, consequent poverty of the family, and the domination of a harsh, strict, possessive mother. Later he suffered from stomach ulcers and high blood-pressure. When he consulted us at the age of 38, these psychosomatic defences apparently no longer were able to disguise the conflict, and he had begun to worry about severe fluctuations of mood, which ranged between depressive despair and rapturous elation and seriously threatened the continuity of his work and home-life. He began to realize that the possessive mother, who was living with him, had not only distorted his childhood, but was also poisoning his married life by her jealousy and suspiciousness. In order to escape from the oppressive atmosphere, which the presence of this witch-like mother-in-law created, and also in order to improve the financial position, his wife had worked as a teacher before Rita was born. The pregnancy was entirely unwanted at that moment, and when it ended in the birth of a second daughter, the young mother was so disappointed that, after breastfeeding the child for 2 months, she left her to the grandmother and continued her teaching until Rita was aged $2\frac{1}{2}$.

While the grandmother was fond of the elder daughter, she took no interest in this second girl. The parents told us quite truthfully that, as no one cared, the baby was often left lying in dirty napkins for hours and got nothing but scolding, when she tried to announce her needs by crying. The child, thus neglected, remained sickly and only stopped bedwetting at the age of 4. Just at about that time, a brother was born.

By the time she was brought to us at the age of $6\frac{1}{2}$, shortly after having started to attend an English convent school, she had developed the following symptoms: She wept frequently over little things and spoke in a loud, shrill and demanding voice. She behaved in a domineering and aggressive manner with the servants and quarrelled with her sister. Even with regard to her parents, she often manifested a bold, insulting behaviour. While, on one hand, she tried to impress others by a certain grown-up emancipation, she would, on the other hand, behave like a baby and refuse to take care of her own needs. She was observed to bite her nails, had a nasty habit of reporting on other children's mischief, true or invented, and, as already mentioned, she had started taking small sums of money from the

mother's purse. Physically, in contrast to the father's huge frame and the mother's fairly tall figure, we found a small, delicate child with a slight deformation of legs and feet, probably due to rickets. She impressed us as nervous, anxious and high-strung. During physical examination, she went into a regular fit of temper.

The little girl was obviously out to compromise her mother not only by demonstrating her helplessness during this outburst of temper, but also in other quite subtle ways : When dressing in the morning, before coming for her first consultation, she had insisted on putting on a tie and belt that did not match her school-tunic, later demonstratively exhibiting this attire before the doctor. She also displayed the hem of her dress which had come undone in one place, remarking that mother only did sewing for the little brother. When, while she was drawing, one of the colour-pencils broke and the therapist jokingly hit it for being so useless, the little girl quite primly remarked that it was not the pencil which was bad, but the shopkeeper. This remark, just as her other demonstrations, obviously had the meaning of blaming and exposing her parents' neglect.

That, apart from neglect, the child also had been subjected to some strict control, was obvious in her way of drawing : all she dared to produce in the beginning, were rigidly symmetrical arrangements of neat little flowers and decorative designs. At times, she would scold her own hand for not doing things properly. She also showed much concern about spoiling a page of the drawing-pad. She told us that at home all her toys were kept locked up, so that she could not damage them. When she realized her freedom, just as Pradeep (78), whose case we have described earlier, she began to revel in unorganized smearing and in using up one page after the other. She behaved like a little monkey and even pretended that she was going to bite the therapist. By the time the family had to leave Lucknow to follow the father on a transfer, not only the little girl had found some release of her pent-up energies, but the whole family-atmosphere had been changed. The father, having gained insight during his own treatment, had had the courage of sending his nagging, possessive mother to one of his brothers; his wife also had profitted by her interviews with the social worker. So there was some hope that the child would be given better scope for her further development.

In this case, one can see, how the treatment of one family-member, if it really reaches to the core of the trouble, can set a whole "avalanche" into motion. Several of our adult patients, when reaching a certain stage in their psychotherapy, not only sent their marriage-partners for talks with the social worker, but also began to become attentive to their children's distortions and they either brought them as patients or sought advice during their own interviews.

In this particular case of Rita, the atmosphere of openness which had been created by the father's prolonged psychotherapy, even allowed the admirable truthfulness

of the parents with regard to their neglect of this child, which, in consultation with a doctor to whom they were strangers, they might have tried to hush up shamefully.

A case in which separation, and not neglect, seemed to have affected the child, is that of a 15 year old Muslim girl :

- (87) *Naseem* was born prematurely, at a time, when her mother was suffering from tuberculosis. She was breastfed for a short time, but later was completely separated from the mother, as apparently the risk of infection was too great. She was looked after by her elder sister, who was hardly of puberty age. A second sister suffered from asthma. Another elder brother and sister were healthy. In spite of the mother's illness, one more sister was born after *Naseem*, so that finally she was the 5th of 6 children. The father, manager of a big estate, had some concern and affection for his children, but easily lost his temper.

Naseem, always delicate and sensitive, was deeply shaken, when, at the age of 8, she had to witness the death of her mother. We were told that she sat beside the dead body in a state of terror and that, ever since that time, she showed great grief and concern, when hearing of anyone's death. She also developed fear of darkness and of being alone. Gradually, this fear spread and also was provoked by clouds, rain and strong winds.

A few months before we examined her at the age of 15, practically at the time when she started menstruation, she had been keeping a fast. A few days later, perhaps in a state of exhaustion, when praying alone in a room in the evening, she suddenly rushed out crying, asking her sisters to pray for God's mercy. She told them that, while she had been praying, someone had put his big hands on her shoulders from behind. Since then, she had gone into repeated fits of anxiety and crying. She felt that she had become someone else and also had the impression that the house had changed. She would frequently spit, arguing that she had to get rid of some bad ideas in this way. She even wanted to avoid sleep, as in her dreams she was terrified by robbers and wild animals running after her. She insisted on sleeping with her elder sister, but would suddenly bite her during the night. She could not even hear the word "death" without going into anxious fits of crying. Her symptoms always grew worse in the late afternoon and towards evening.

The delicate, small girl looked younger than her age. Her face was distorted with terror. In a childish voice, she complained of anxiety, in particular of fear of being alone. Even her steps were short and timid, like those of a very small girl. During physical examination, which only revealed the vegetative signs of anxiety, she refused to close her eyes even for a few seconds, as she could not trust that nothing frightening would happen meanwhile. She complained of the doctors who had only prescribed medicines without taking the trouble to talk

to her in a kindly and gentle manner, and was quite sure that such medicines could not possibly do any good.

Rather in contrast to all her delicate helplessness and anxiety, was the obvious pleasure with which she entered into a kind of tug-of-war, when we tested the strength of her arms. We also noted bitten nails, always a sure sign of pent-up aggression.

While a person who dares to give his aggression free course, will "fight tooth and nail", the one who suppresses his aggressions, either because he wants to ignore them or because he is too weak to face an opponent, seems to "fight tooth against nail", in an attempt at limiting the struggle so-to-speak to the "home-front". As, however, not all energies are consumed in this very minor battle of tooth against nail, which provides hardly any motor outlet, aggressions can still flood the organism and cause physical symptoms, invade the dreams and even change the outside world into a threatening and terrifying realm, from which some danger or disaster may jump at one from any corner, as soon as one relaxes one's watchfulness.

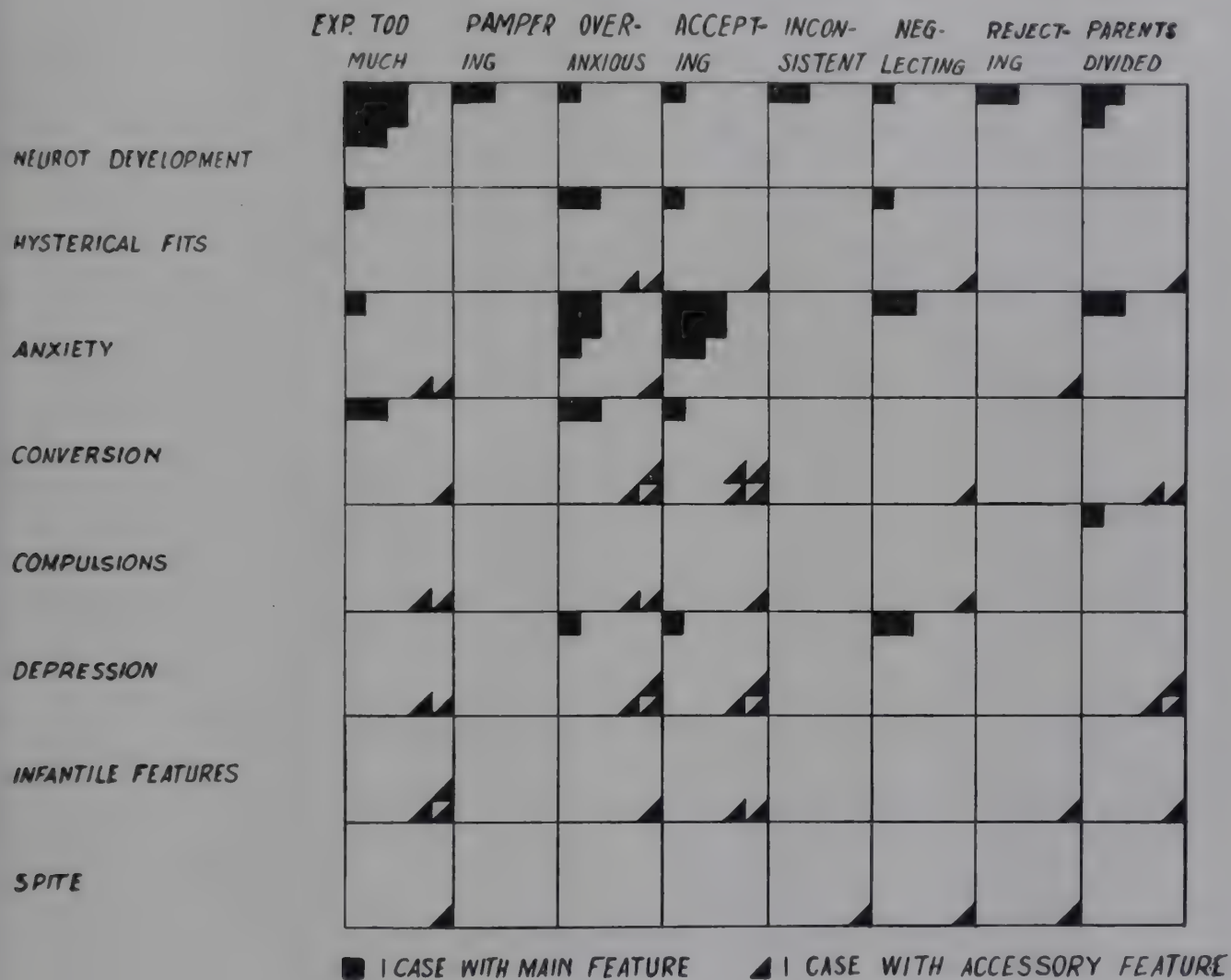
Our little patient admitted some anger and aggression, but could not define them. Equally, she told us that the world seemed to have changed, but also could not say, in which way. When we tried to explain to her that she must be angry with a world that had denied her the shelter of a mother's love at so early an age, she went into loud weeping and threatened to run away, if we were going to talk about so terrible a thing as death. All she wanted, was to remain in a quiet, peaceful place, where she could play with children ! We did not get a chance for further exploration beyond the first interview. It is very likely that this delicate girl, who had lost her mother, not only at the time of her actual death, but already long before, in early infancy, through the restriction of contact due to the infectious illness, resented her having to grow up into a woman, before she had really finished being a child.

Her state of anxiety, particularly the experience of a changed world and a change in herself (symptoms of "derealisation" and "depersonalisation"), bordered on a schizophrenic psychosis. Expert treatment would have been urgently indicated. But the family, who were full of superstitions about the causes of illness and about "hot" and "cold" medicines, did not bring her back.

We have mentioned that Rita (86) was an unwanted child. The only other case, in which the parents explicitly mentioned that the child was unwelcome, is that of a little boy, whose rather perfectionist and ambitious mother resented that this first pregnancy, 3 months after marriage, spoilt her chances for further education. This mother thought of abortion, but did not try it. The mothers of two other children had provoked abortion during other pregnancies, but none of the children examined by us were born after attempts at interrupting the pregnancy.

Graph 5.

Neurotic Symptoms and Parental attitudes



(16) *Parental Attitudes* (Graph VII).—If parental attitudes already play an important part in the development of children handicapped by congenital and organic disabilities, one may expect that their role would be even more prominent in giving rise and in shaping a disorder of purely functional type. It may therefore be rather surprising that, what we have called “acceptance”, accounts for the greatest share of neurotic children. This looks, as if the attitude of the parents were not always the distorting factor or at least as if it could only become so in concurrence or possibly in contrast with other influences. We have already repeatedly ventured an explanation for the low rate of parental acceptance amongst children of the congenital and organic groups who presented a neurotic overlay, in contrast to the relatively high proportion of “accepting” parents in the “pure” neurotic group : For handicapped children, the home atmosphere and in particular the care of the parents, constitutes far more exclusively their whole world. This close dependence of course renders them more susceptible to any faulty parental attitude. On the other hand, the child’s very handicap may encourage the parents in an unsuitable attitude of either taxing the child beyond his capacities or using his weakness as an excuse for clinging to him, watching over him with overanxious concern or losing interest in what is so poor a means for realizing their ambitions. Against this, the originally healthy child has not only more ability, but also more opportunity, to stand up for himself and to seek healthier stimuli elsewhere, if the atmosphere created by the parents is not wholesome.

On the other hand, children who grow up in a harmonious home, in which they have to face no difficulties, no factors that contrast with their own inclinations, may be ill-prepared to emerge from this congenial shelter into a world with which they have not learned to deal. Furthermore, we have already noted earlier that, what one may reasonably term as an “accepting” attitude in parents, *i.e.*, a way of bringing up a child that would perhaps suit an “average child” and that obviously has suited other children in the family, may possibly go against the grain of a child who differs from the other siblings or who is, as we expressed it, a “freak” in the family.

Hoping to gain some insight into the role which “parental attitudes”, and in particular parental acceptance, play in the origin and structure of neurotic manifestations, we have established a graph (Graph 5), which shows the combinations of the various parental attitudes with the neurotic symptoms found in the children. In this graph, the parental attitudes are lined up in the horizontal axis (with the same designations as in Graph VII), while the symptoms occupy the vertical axis. The small squares arranged in the left upper corner of each field, indicate the number of children in whom a certain symptom is the main manifestation, while the triangles in the right lower corner mark the accessory features.

If we now examine the “results” of the different parental attitudes one by one, we arrive at some interesting observations : The attitude of “expecting too much” seems to find its most frequent response in a “neurotic development”, *i.e.*, a certain uniform

distortion of the child's whole development, which may, however, be marked by accessory features, amongst them in first line infantilism, depression, compulsion and anxiety. Second in frequency as a main feature comes "conversion". Both, "neurotic development" and "conversion" (including stammering), represent forms of neurosis in which concealing and repressing rather than revealing and expressing determine the symptomatology. This is the result one would expect : a child who depends on the parents who provide for him, naturally has to try to come up to their expectations. In this process, any weakness, any features that do not tally with these demands, have to be hidden or at least expressed in a way that does not suggest one's own responsibility for the phenomenon.

Pampering also seems to breed a general dysharmony of development. In both the cases registered in this category, expansive features were noted : a severe degree of moral depravation and delinquency in an adolescent, and signs of revelling in an exuberant sense of omnipotence in a 4 year old boy.

Overanxiousness in the parents has its counterpart in anxiety in the child. Probably according to the varying balance between tendencies towards revealing and concealing, this anxiety is in some cases expressed in superficial hysterical manifestations, while in others it is disguised more deeply in a physical conversion symptom. Conversion and hysterical manifestation also figure amongst the accessory symptoms, side by side with depression and compulsion. We can assume that, according to his stronger or more asthenic nature, a child will either be swept away by the parents' anxiety in the latter case or, on the contrary, try to resist it and to conceal his own anxiety not only from himself, but also so as to save the parents from additional worry; then, symptoms like conversion, depression or even compulsion may have to be built up.

The column for parental "acceptance" is marked by an obvious accumulation of cases with manifest anxiety. All other main symptoms, such as neurotic development, hysterical manifestations, conversion and depression, only occur in single cases. As accessory features, we find mainly conversion and depression. This distribution of symptoms in children whose parents do not appear to show any evident deviation from normal concern, seems to lend weight to our assumption that anxiety, one of the most fundamental human experiences, characterizes situations in which individual separateness and limitation, and consequently also individual responsibility are realized as contrasting with the sheltered situation of being enveloped and carried or even merged in a congenial atmosphere of collective or symbiotic living. Even a child growing up in a harmonious family cannot be spared situations like experiencing himself as distinct from others in illness or when exposed to an exam or some other ordeal, or like realizing the limitation of all human existence through the death of a relative or acquaintance. Above all, any child whose mind has been developed by modern education, will go through a phase in which individual consciousness and conscience try to emerge, at the time of puberty. Children who have been well-sheltered, who never had reason to feel the gap between need and fulfilment, to experience the clash of different subjects

asserting themselves against each other or the need for resisting invasion by attitudes contrary to the moral ideals of the family, are far more likely to be shocked and caught helpless, once they have to face such adverse situations, than those children who have been subjected to a gradual process of "immunisation" in a less congenial atmosphere. While in the West, this process of realizing oneself as separate, is encouraged right from earliest infancy, Indian culture, up to the present change, had rather fostered symbiotic forms of living.

One might profitably illustrate this statement by a metaphor taken from the realm of biology : As long as a cell, *e.g.*, a blood corpuscle, is suspended in a fluid with more or less equal osmotic values (*i.e.* containing similar substances in a similar concentration), there is no need for establishing a strong cell membrane with well developed powers of selective permeability. A free exchange in both directions is possible. If, however, a cell used to such equal surroundings, is brought into a medium of different composition and concentration, it will, unless it can speedily reinforce its membrane, be invaded, poisoned, washed out, to the point of either bursting or shrivelling up.

Again, in a process of this kind, we can imagine two main possibilities, which actually correspond to what one can observe with regard to "osmotic resistance" of the red blood-cells : If the membrane is of average strength and permeability, only a very sudden and drastic change of the composition of the surrounding fluid can damage it. If the membrane is fragile, even minor shifts in the chemistry of the medium of suspension can affect it.

Similarly, there can be certain human situations, which, in their suddenness, their unusual nature and intensity, can invade even well defined limits of a human individual while the person with a "membrane", which is either constitutionally weak or which, in congenial surroundings, has had no chance of developing powers of selecting and resisting, will be affected by much less significant influences. It is interesting to note that, in English, as also in other European languages, many expressions which we use in a customary metaphoric connotation without reflecting on their original meaning, seem to refer to the very processes of osmotic resistance, which we have just used to illustrate our thought : "Influence" means something that "flows into" ; we talk of being "impressed", which suggests a surface that does not put up resistance, but can be "pushed in" by some force from outside ; after moving in a big gathering of people or a strenuous day's work, one may complain of being "washed out" or that "they have taken it out of me" ; similarly, if one calls an atmosphere or the contact of a certain person "poisonous", this implies that something in it succeeds in penetrating a defenceless membrane into an organism that has no means to assimilate it, *i.e.*, to turn it into its own substance !—The Indian preoccupation with "chhuachūt" and "lagāna" ("Kuchh lag jaega" !), on the other hand, might indicate an even more sensitive "membrane", which can be hurt not only by invasion, but already by mere touch.

The problem of emergence in present time India is not only one of leaving the family atmosphere for a different world outside home, but of a quite universal transi-

tion from a social structure that delimited groups of similar climate or "osmotic value", within which no great need for strong individual membranes existed, to a more open and competitive order of society, in which the individual is more likely to come up against "influences" not congenial to him. Against the risk which this change brings with it, even a harmonious family-life and an accepting parental attitude cannot always protect a child.

The parents' "inconsistent" and unpredictable attitude seems to find its reflection more in an over-all distortion of development than in any one particular feature.

To "neglect" and lack of understanding, children respond predominantly with anxiety and depression, while against more complete "rejection", our examples had to arm themselves with a neurotic character structure, including anxiety, spite and infantile features.

In estimating the result of diverging parental attitudes, one probably would have to take account of the different combinations possible, which one finds demonstrated in Graph VII a. If we only consider the divergence as such, without further specification, it seems to provoke most frequently neurotic development and anxiety, with depression and conversion as preferred accessory features. It is interesting that the only case (Iqbal, 71) in which compulsion was regarded as the dominant feature, is to be found in this column. The inner contrast between conflicting forces, which has to be bridged by the compulsive compromise, often seems to be the reflection of a similar dissension first experienced in the outside world in the attitude of the parents or other family members.

The graph (Graph 5) can of course also be read in the other direction : Instead of examining, what symptoms are produced by various parental attitudes, one can investigate the columns for the different symptoms and see, what parental attitudes seem to be most frequently associated with them. To name only the most obvious combinations, we then find that "neurotic development" seems to thrive, when parents either expect too much or if they diverge in their attitudes. Hysterical demonstrations seem to find a fit audience in overanxious parents. A child's anxiety is likely to be manifested in its open form, where anxiety is "in the air", or where harmonious, accepting surroundings have not prepared him for disturbing influences outside the home. Conversion as a main symptom matches the exaggerated demands and anxieties of parents. Compulsion as a main symptom is found, where the parents differ in their attitudes and, as an accessory feature, again where the child has to defend himself against demanding and anxious parents. Depression is provoked by neglect, but also, to a minor degree, by parental dissension and by the situations that also result most in anxiety. Infantile or regressive features, seem to represent a preferred reaction to excessive demands, but can also develop under parental acceptance. Spite is found as a defence against all attitudes that betray lack of concern and, in addition, against excessive parental ambition.

Of the cases of "borderline psychosis", which are not marked in Graph 5, four had parents with diverging attitudes, 3 each came from families in which normal concern or overanxiousness dominated the atmosphere, and 2 had been subjected to neglect. The only features that coincide with the distribution in the group of psychotic adolescents, are the absence of "excessive demands" and "rejection" and a relatively high percentage of "accepting" parents.

Once again, we have to warn that, as our material is small, the figures may have been affected by chance more than by any inherent regularity. The results of this graphic representation, however, on the whole do not go against any reasonable expectations and may deserve confirmation or modification through study of some more extensive material.

A short explanation may be indicated with regard to the predominance of attitudes that betray "overconcern", in particular excessive demands and overanxiousness, over those which could be summed up as lack of concern (Graph VII). We cannot conclude from this distribution that parental attitudes of overconcern are more likely to provoke neurotic reactions in the children than attitudes of relative neglect. All we know is that children of overconcerned parents are more frequent in our material. It may well be that parents who neglect or even reject their children, also do not bother about bringing them for consultation or treatment.

Though the case histories already quoted throughout the text of this chapter have illustrated quite a few of the parental attitudes, we shall now add, as far as possible, one example for each column, choosing it amongst the symptomatic category which is most frequently represented as a response to the particular parental attitude.

To illustrate the combination of excessive parental demands and a neurotic development, we propose to quote :

- (88) *Nazar*, a Muslim boy of almost 16. He was brought by his father, a rich businessman, because of his inability to profit by his studies and his general lack of understanding. The boy himself complained of "weakness of mind", inability to spell, deficient eyesight and pain in his back. He was physically weak and little developed for his age. Irregular teeth and a slight anomaly of the toes betrayed a certain degree of congenital dysplasia. We found a slight deformation of the dorsal spine, which corresponded to the pain he indicated. X-ray investigation showed a lack of minerals in some of the bones, partly due to a crisis of growth, partly to congenital syphilis, which was confirmed by blood-tests. One may wonder, whether the mental weakness may not equally have been a symptom of some syphilitic affection of the brain. We had, however, reason to assume that it was much rather a consequence of neurotic distortion, though the parental infection may have provided the basis of a weak constitution.

The boy, eldest son, born after one sister, had been sickly since infancy. He suffered from liver-trouble, when a small child. From the age of 12, he had to wear glasses to improve his poor eyesight.

After him, 5 more children were born, 3 of them boys. One sister died. One child was born dead in a state which again suggested parental syphilis. The next younger brother, who had reached beyond Nazar in his studies, was a stammerer.

The father described himself as bad-tempered. Apparently he had been rather happy-go-lucky and careless up to the death of his own father. Then, under the weight of family and business responsibilities, he became more calm and settled. Even then, however, the children were afraid of his unstable moods. He provided well for their material needs, but had no emotional concern for them. It looked, as if, after having had to give up his own youthful irresponsibility, he grudged his offspring their own carefree childhood. Consequently, he placed high demands on them, particularly on this eldest son, whom he expected to be well-behaved, studious, responsible and courageous. The sensitive and physically weak boy did his best to live up to his father's ideals. But when he had to accompany him on "shikar", he felt miserable and sorry about any deer that was shot. His duty, as the eldest son, of killing the sacrificial goat on a certain festival was a terrifying ordeal for him. The same fear of being called a coward by his father had made him keep silent about the pain in his back, until we impressed the seriousness of this affection on the family. He had to struggle all the harder to keep up his position as an eldest son, as his younger brothers were healthier and smarter, advancing in life with more ease than had been granted to him.

The mother lived in strict purdah and seemed to spend most of her time in prayer. She too expected her eldest son to fulfil his duties, without much concern for any of his problems and sufferings.

The result of these expectations on a boy who had been put into the world with the permanent marks of the parents' sins on his weak body, was to be seen in his poor achievements in school. He was not unintelligent. But, confused by having to learn 3 languages and 33 scripts (Urdu, Hindi, English), exhausting his strength in trying to keep up with paternal ambitions, and struggling against physical odds, he just could not master the intricacies of spelling, nor could he shine in dealing with figures, when trying to help his father in business.

He was depressed and apathic, and it took some time until he felt sufficiently confident to open up a little. One could see that he was a very sensitive boy with an extremely soft heart for all human suffering. His responses to projective tests betrayed a spirit of resignation and hopelessness, fear of being mishandled or even killed.

Fortunately, in this case, we were able to work through the boy's tutor, who was deeply concerned about his pupil. He succeeded not only in forcing through, against the parents' carelessness, the necessary physical investigations and treatments, but in stimulating the boy into resuming interest in games, stamp collecting and other hobbies that could give him confidence. It was mainly thanks to this fine, truly philanthropic tutor, that, 3 to 4 years after we examined the boy, he was usefully employed in his father's business and an appreciated member of a prominent hockey-team.

Of the only two cases of pampering, one will be mentioned in the chapter on delinquency. The other one is to be given here :

- (89) *Ajit* was the youngest of 3 children of a Brahmin university lecturer. One sister, $2\frac{1}{2}$ years older and a brother one year older, presented no extraordinary features. Ajit was born without complications and, in early infancy, mostly taken care of by an ayah. Since the age of 1, he had occasionally had convulsive fits during fever.

When he had reached the age of 4, the parents came for advice, because the boy was very impulsive, restless, mischievous and destructive. He was constantly on the move, and nothing was safe from his inquisitiveness. He could not be checked in his hyperactive exploration of the world even by occasional scolding and beating. The parents' behaviour towards the boy, during their visit at the Center, gave us the impression that they had been far too lenient with him. As, since infancy, he had promised to be a particularly intelligent and enterprising child, everyone had been admiring the "cute little fellow" and watching his pranks and manoeuvres with amusement and pride. At the time when the parents brought him, they still showed, on one hand, great admiration for their precocious "wonder-child" ; on the other hand they were utterly defeated, as he had grown quite out of their control. We ourselves, at the end of one hour's exhausting interview, had to sum up our verdict : "He is a charming little fellow ; but he certainly is a handful !" Tall, sturdy and broad, but with still rather babyish body proportions, the boy could hardly be quiet for a moment. In the shortest time possible, he had not only explored all the toys, handling them with considerable mechanical skill and a joy in loud noise, but also investigated all the switches for lights and fans and filled the water-basin to the brim, so as to see what would happen, when it overflowed. When limits were set firmly, he could obey. But it looked, as if at home he had been left to enjoy his sense of magic omnipotence with very little restriction and as if there had been no area kept "reserved for adults".

In the West, it is one of the principles of home education, though perhaps nowadays it may be getting a bit "old-fashioned", that, up to a certain age, children should obey parental authority without questioning the reasons, just because it is good for

them to have certain limits fixed and consistently kept. Here in India, one often observes that, no matter whether at home or in some public place, nothing is "forbidden" for children. The reason for this permissiveness is probably again not so much a real concern for the child's ultimate welfare, but the parents' inability to be firm and to witness and bear empathically the child's sense of frustration.

In our example, the matter-of-fact way in which this small boy handled all technical devices, probably imagining that *he* had set the fan going and that *he* had made the light appear, filled us with some horror. Is this what the young generation will grow up to in this technical age? Comfort and ease without effort? Magic control over enormous powers without realizing the amount of human thought, endurance and plain, hard labour that has gone into making a switch produce a light at their command? A wrong sense of self-importance, resting on nothing but the pampering, exaggerated admiration of doting parents?

All we could do, was to advise the parents to set firm limits to the child's expansiveness, to face him with tasks and materials that would oppose some resistance to his sense of omnipotence. At the age of 4, he was still a charming and amusing rascal. But we could already visualize, what he might be 10 to 15 years later, when he might have exhausted his wildly overflowing energies, just at the time when facing resistance from without and within would have become a necessity.

There must be plenty of such little Ajits nowadays in educated families. The danger is that they are seldom recognized as problem children, but generally admired and praised as model—or wonder-children! If, however, they cannot learn to contain and economize their energies and interests and to face resistance, the period of adolescence with its unavoidable strains may reduce them to miserable wrecks.

A girl who was infected with anxiety by the overanxious attitude of the parents, is Fatima :

- (90) *Fatima's* father, aged already 56, when he brought her at the age of 14, was easily upset, anxious and worried. The mother was sickly and, since early menopause, already before the age of 40, had hardly seen a healthy day. Her troubles were probably of functional type. She was short-tempered, domineering, and had some compulsive habits of washing and cleaning. She would constantly fuss and nag about the patient's dress and manners, which she expected to conform to her old-fashioned ideas. She would use the threat of heart-failure to force the children into obedience, a practice which can leave severe guilt-feelings in a child. The 4 surviving elder children, —one had died in infancy,—seemed to have managed to grow out of this possessive and anxious grip. *Fatima*, being the youngest, remained caught in it. She was only partly breastfed, as the mother did not have enough milk. She learned to walk at 1½, to talk at 2 years.

After starting school at 7, she was the best pupil up to 8th class. In 9th class, due to change of the teaching medium, she only attained 3rd position and felt disappointed about it. After already having shown the first signs of her illness, she passed her High School exam., but with poor marks. From the age of 12, she had to wear a burqa and keep "purdah". One year later, she started menstruating. No explanation was given to her. She was disgusted with this sign of physical maturity, in which she could only see something as dirty as any other excrement.

When the girl was first shown to us at the age of 14, she complained of anxiety, in particular fear of darkness and being alone, lack of concentration, a buzzing sound in her head, tingling sensations in her limbs, frequent urinating, excessive thirst, nausea, constipation,—again the physical expression of acute anxiety, as we have seen it in earlier examples. In addition, however, she presented alarming signs that made one wonder, whether she had not already crossed the border towards psychosis. She at times went into unmotivated fits of crying and laughing or even into violence and hinted that she could see snakes in the dark. She refused to sleep alone and, at night, clung to her mother, who probably stepped up the girl's anxiety by her own neurotic behaviour. She also had a habit of spitting and was very much worried about her constipation, because this meant that "dirt" was getting accumulated inside her. Asked about her dreams, she described jungles and snakes and a vague impression that "something was going to be swallowed by something", probably a fit expression of her vague sense of impending disaster.

Though the father was a doctor, he did not follow our advice about the need for prolonged expert treatment. After 3 visits, when she had improved sufficiently to pursue her studies, she did not return.

3 years later, we saw her again, still in a similar condition, but with more signs of psychotic deterioration. She was now talking and laughing to herself, anxiously clinging to her father, bursting into anger, whenever anything went against her will. The visual and auditory sensations, which during the first visits could still be regarded as illusions of a vivid imagination, had now assumed the character of hallucinations : hearing "voices", seeing snakes, feeling insects crawling on her. Her orientation in time had crumbled, and she faced the general disintegration with anxiety and puzzlement. Even at this stage, the parents did not accept our offer for in-patient treatment and did not bring her back after one interview.

We next present a case which did not seem to be characterized by any obviously faulty parental attitude, and in which anxiety was the main feature :

- (91) *Sudha*, a tall Baniya girl of almost 16, was the 5th of 9 children. Amongst the 4 children elder than her, there was only one sister ; she suffered from puerperal

psychosis after her first delivery. Next to Sudha, about $1\frac{1}{2}$ and 3 years younger, 2 further sisters were born. The 2 youngest children in the family were again boys. For the last few years, since the sister's marriage, Sudha had thus been the eldest girl at home.

About the parents, we knew that the father was very busy in his work and at times a bit short-tempered. The mother was calm, and the children were much attached to her.

Sudha was breastfed for more than a year. She was a healthy, chubby baby, until, at the age of $1\frac{1}{2}$, an attack of typhoid somewhat reduced her physical strength. Since infancy, she was rather quiet and never made a fuss. When she was hurt or disappointed, she would console herself by sucking her thumb, a habit which she kept up until she was 11 years old. She started school at the age of 7, and was an average pupil. She made friends easily, could talk without much inhibition to outsiders and, apart from her studies, was helpful in housework and sewing. Occasionally, she would quarrel with her siblings.

At the age of 14, she started menstruation. Already 1 to 2 years before, she had begun to grow rather rapidly. When we saw her at almost 16, she definitely stuck out in her slim tallness. Just as Amrit Kaur (67), the other unusually tall girl we have already presented, she felt embarrassed by her size, which exposed her to being taken for elder than she actually was. A first attack of anxiety and depression, which however yielded to some treatment, occurred at the age of about $14\frac{1}{2}$. One year later, she got confused during her High School exam. After having "spoilt" one paper, she did not appear for the further tests. Later, she regretted having missed the chance of passing at least with moderate marks, because she now found herself in the same class as her younger sister. She became anxious and sleepless, complained of headache and pain in neck and shoulders. At times she felt, as if someone were standing behind her, a symptom which we have seen in even more scaring form in Naseem (87).

When we examined her, she indicated lack of sleep and appetite, giddiness, anxiety and a general feeling of insufficiency. She described how, whenever seeing any work before her, she would feel that she could not do it. She had become afraid of talking to people. She was always apprehensive that someone might scold her or that she would have to be ashamed of herself; in short, everything one could sum up under the term "self-consciousness". She explicitly stressed, on our questioning, that no one else in the family had pushed her into her higher studies, nor had anyone reproached her for her failure in the exam. She herself was ambitious and could not suffer, that the younger sister had caught up with her.

She obviously was torn between pride of being grown-up and superior to the younger sister and, on the other hand, regressive tendencies, which made her cling

to her mother like a small child. Another conflict, of which she had become aware recently, was her wish of standing up for what she was, *e.g.* for a certain simple, natural taste in clothing, while, on the other hand, she did not want to deviate from the current fashion which her friends followed and which she really detested. She had plans of going in for higher education, but felt distressed, because already at High School level, the less educated mother no longer could provide intellectual shelter for her. All these conflicts were pulling her so much apart, that at times she feared that she might go mad. At night she had dreams of a man running after her, wanting to beat her.

Suitable medicines and her finding, in two long interviews, understanding for her problems, which are typical for many adolescents, seemed to give considerable relief to the girl.

The history did not indicate any particularly unsuitable attitude on the part of the parents. The girl's position in the family contributed to her difficulties insofar as, after the elder sister's marriage, she had to take the place of the eldest girl, with a slightly younger and apparently more robust sister pushing from below. The fact that her physical tallness made her awkwardly conspicuous, may have precipitated the process of "becoming conscious of herself" and the feelings of insufficiency and anxiety associated with it. The value set on higher education had made her grow out from a position in which she could look up to her mother in all respects, and the ambition to follow her school-mates in fashion brought her into conflict with her own true nature.

One sees that the main outward factors which we can accuse for having precipitated the disturbance, are of a type to which many young people are exposed nowadays.

Whether they can resist the storm, or whether they are bent or broken by it, may ultimately depend on an inner speed and rhythm of maturation, and the courage and wisdom of both, child and parents, to keep outward development adjusted to it.

Both children who had to face inconsistent behaviour on the part of their parents, presented delinquent features. They therefore will be presented later.

Neglect by a psychotic mother and a preoccupied father, seemed to be partly responsible for the anxiety of another young girl, this time from a Muslim family :

- (92) *Farzana*, aged 15, when we first saw her, was the 7th of 11 children. Of the 6 elder siblings, one sister and one brother had been treated at our Center before 1956, both for neurotic symptoms bordering on psychosis. As both elder sisters had left the home after marriage, Farzana was the only girl amongst 8 brothers, the eldest aged 22, the youngest 9. Her mother was suffering from paranoid psychosis.

When the girl was aged about 17, the mother left home and kept roaming about near some pilgrimage place. So, in an all-male household, the young girl was not only forced into early responsibility, but also exposed to becoming aware of herself as different and separate.

At the time when we saw the girl first, the mother was still at home and had accompanied her to the Center. She made a suspicious fuss about our seeing the girl alone and kept coming into the office, hovering over her like an evil spirit. One could, however, see that she was so preoccupied with herself, that she certainly was not capable of giving adequate care and concern to her daughter. Her leaving the family some time afterwards, brought her carelessness completely out into the open.

The father was a weak, irritable man with no authority over his wife, and incapable of proper care for his children. Unless one of the elder brothers had shown some concern for Farzana, she would hardly have had a chance for treatment.

At the time of the first consultation, the symptoms : anxiety, sleeplessness, fits of crying, lack of interest, frequent urinating and headaches, had only been noted for the last 3 months. It seemed, however, that she had already shown a certain change since menarche at the age of $13\frac{1}{2}$. When menstruating, she would urinate into her clothes or into her bed, apparently out of protest against this humiliating female function and out of disgust with anything concerning that "dirty" part of her body. She was loaded and sparkling with aggression, which seemed to be mainly due to her resentment against having to grow up as a woman. Quite generally, one had the impression that a very lively, emotional temperament could find no suitable outlet.

At that time, the girl came only for one consultation. The neglectful attitude of the parents showed itself in the fact that she was only brought back 3 years later, in an almost psychotic state. At that time, we had ample occasion to observe her, even as an in-patient. This phase of treatment however, took place at an age with which we are not concerned now. The two features of parental neglect and her own anxiety were, if anything, still more obvious when she was 17 to 18 years old.

Of the two cases in which parental rejection was fairly obvious, we have already quoted Veena (79). One other case, a boy, will be demonstrated in the group of children with delinquent features. One might expect to find Rita (86) in this group, as she, no doubt, was an unwanted child and a victim of rejection or at least neglect. By the time we examined her, however, the parental attitude was more characterized by expecting too much of her. She is therefore listed under that heading.

We finally have to give an illustration for diverging parental attitudes :

- (93) *Yogendra* is one of the children whose father was well known to us as a psychotherapy patient. He was the 4th of 9 children. The only boy born before him, as the eldest, was 10 years older. *Yogendra* was breastfed up to the age of 1½. At the time of weaning, he developed liver-trouble. He remained sickly and often suffered from fever. At the age of 5, he had a severe illness, which was diagnosed as meningo encephalitis. Though no physical defect resulted, the child became irritable and quarrelsome. When, at the age of 6, he was sent to school, he could not concentrate and took no interest in his studies. He preferred to play about with balls, kites and marbles. It is of course possible that these disturbances may have been partly due to some brain-damage which could not be detected by physical signs. On the other hand, the boy had plenty of other reasons for developing in a distorted manner : The mother, a warm-hearted, but rather robust and somewhat-irritable woman, favoured this boy, for whose life she had sacrificed so much effort and prayer during his severe illness. The father, who quite generally resented his big family and the financial burden it placed on him, reproached him with not studying and cursed him as a good-for-nothing. He himself, however, in his hypochondriac preoccupation with his neurotic symptoms, was in no way a stimulating masculine model for his sons.

On examination, we found a rather thin boy with hunched shoulders. His movements were a bit hasty and erratic, and his speech at times stammering. He seemed embarrassed and restless. In some tests, he proved to be somewhat distracted, but certainly not unintelligent. He showed particular interest in solving problems that required some manual skill. His responses to projective tests betrayed resentment against the father and a rather childish clinging to the mother. He certainly presented features that were not quite "up to his age". After the severe illness, however, a certain amount of slowing up and regression was to be expected. In view of the undue haste in his movements and speech, the mother's kind, permissive attitude was more likely to ensure the best possible development than the father's reproaches and curses, which did not spring from any real concern for the child's welfare, but only from the father's own wish of seeing his sons grow up quickly, so that they might support him !

One may remember that, amongst the parents of children with congenital and organic handicaps, who showed divergent attitudes, we usually found the father more understanding and accepting. This example of a neurotic child definitely shows the mother in a better light.

While in a small, nuclear family, the parents are those who are most likely to shape a child's development, other relatives have a chance of making their influence felt, where the family is an "extended" or "joint" one. Where several generations live together, the parents may not have reached any position of authority while their children

are growing up. The father of Yogendra (93) just quoted, had practically never known his own father as anything else but the docile and dependent son of the very powerful and longlived grandfather. For Pradeep (78) too, if anyone really played the role of the father, it was more the grandfather than his own mentally ill father. Even in smaller families, however, relatives other than the parents can play a significant role : Farzana (92) was practically left to the care of her elder brothers, while she had to play the role of the mother for the younger ones. In the family of one delinquent adolescent, an elder sister was the only one who really showed concern about his behaviour and who brought him for consultation.

We should like to add one example, in which the influence of one of the grandfathers seemed to be a decisive factor in the development of neurotic symptoms. This case, at the same time, illustrates again, how the beneficial effect of an accepting parental attitude can be counteracted by other factors :

- (94) *Kusum*, a Baniya girl from a joint family, was brought for consultation at the age of 15. For the last 3 months, she had shown signs of anxiety and depression. She complained of palpitations, a sensation of suffocation in throat and chest, headaches, tingling in the limbs, general tiredness and fits of weeping.

On examination, we found an enlarged thyroid gland, which may partly have been responsible for the physical symptoms. On the other hand one knows that a swelling and hyperfunction of this gland can in its turn be a psychosomatic manifestation of suppressed emotions, which, so-to-speak, "get stuck in the throat."

The mother, during the earlier years of her marriage, had gone through two psychotic episodes and still had hysterical fits occasionally. The father was rather strict in discipline. On the whole, however, both parents seemed to have some understanding and true concern for their children.

Kusum, born as the second of 8 children, but remaining the eldest surviving child amongst 6, had developed normally up to the age of puberty. Menstruation had started a few months before we saw her, and she had shown the first symptoms of nervousness shortly after it. During this critical phase of biological change, the girl had had to "swallow" two great disappointments : Starting school at 6, she had always been first in her class and had taken great interest in learning. Her parents put no obstacles into her way towards higher studies. The old-fashioned paternal grandfather, however, did not approve of girls' education and ordered that she should leave her studies after 8th class. At the same time, about 4 months before the first consultation, equally on command of the family tyrant, her marriage was arranged. Seeing how frustrated the girl felt about having to give up her hopes for higher education, the mother, to whom Kusum was very much attached, took her to her own relatives, where, out of the paternal grand-

father's control, she could have continued her studies. There, however, the mother, possibly in dilemma between her concern for this daughter and her other duties at home, developed hysterical fits, which scared the sensitive girl.

Her response to projective tests (Thematic Apperception Test according to Murray), brought out a whole tangle of anger, fear, resentment and helpless attempts at opposing restraint. As, however, any struggle on an "outward front" seemed to be impossible after she had to return home with the sick mother, these emotions had to find something to work on in her body.

While in the examples mentioned, the influence of some other family-member played within the home, counteracting that of the parents, the children were, in some other cases, left almost exclusively or at least temporarily, to some other relatives. Amongst them, of course, are some who had lost their mothers ; others still had their parents, but for some reason did not stay with them. Veena (79) for instance, was taken to her grandmother's home, where she found more understanding than with her rejecting parents.

Two examples of cases in which there seemed to be a certain rivalry between parents and other relatives, are the following :

- (95) *Abu*, a 7 year old boy, was the only child of a Muslim cousin marriage. One of his great-uncles, as the patient himself, was a stammerer. One great-aunt was mentally ill. A maternal aunt had epileptic fits. The father, a businessman, was rather irritable and worrying. He had suffered from tuberculosis. The mother herself fell ill with meningitis, when Abu was aged 15 months. Up to that age, the child had developed normally. When the mother became ill, breast-feeding had to be stopped abruptly, and he suffered from digestive trouble and swelling of the liver, complicated by pneumonia. He was separated from his sick mother and brought up by his maternal grandmother. When, after 8 months, during which period he also was ill most of the time, he again met his mother, he would not recognize her and refused to talk to her for about one year. He continued to live with his grandmother. At the age of 3, after a febrile illness, he started stammering, while previously his speech had been clear. One year later, at 4, he had to start school, and, in addition, got religious instruction by a tutor at home. At the age when we examined him, he lived with his grandmother during school-terms, while he spent his holidays with his parents. Even at that time, however, he would not recognize his mother as such, but still considered his grandmother as his real mother. This estrangement was all the more disappointing for the mother as, after her severe illness, she could not have any further children. Though she resented the grandmother's claim on Abu, she was irritable and often scolded him, when he was with her. Possibly the grandmother's ambition of proving to the child's parents that she could give him a better education and that therefore it was in his interest to stay with her, may have prompted her in pushing him excessively in his schooling.

The boy was brought from a town far from Lucknow, on advice of a general practitioner. Apart from his stammering, which was not very obvious, the family had been worried about his weak appetite and fussiness about food, his grinding his teeth during sleep and some compulsive habits of cleanliness.

Again, as in the previously presented stammerer Anil (81), we found a child who had been pushed too early and too intensively into intellectual effort and discipline, while his childish, playful tendencies had been given no outlet. He produced an amusing drawing of a boy, his round stomach filled with "chupattis", running home from play. He added rather sadly that he himself never had time to play, but always had to learn.

- (96) *Amir*, another Muslim boy, aged 12, the only son of a Government official, born after 2 sisters, had, at the age of 8, been taken away from his family in a village by a rather authoritarian paternal uncle, who wanted to give him "a good education" in the city. It seems that the uncle's family was not only more educated and emancipated, but also more disciplined than the boy's own parents. While, at the uncle's house, the boy behaved well, he used his holidays at home for all kinds of mischievous pursuits, as *e.g.* torturing animals and playing with fire. When, at the age of 12, Amir was at home during his summer holidays, he witnessed the hysterical fits of a cousin-sister. Shortly afterwards, when one day he was scolded for playing with fire, he went into a fit of anger and cried for 3 hours. Later, attacks of a slightly different type occurred: He would go all limp and first remain quiet in an "unconscious" state. After a while, he would start whispering angrily, talking of skinning, beating and punishing other people. After the fits, which might last from 10-30 minutes, he would not remember anything.

One might hesitate, whether to regard these fits as hysterical or whether one should assume an epileptic component. We know that several relatives on the father's side had been mentally ill; but no epilepsy had occurred in the family. The boy himself had never had any convulsive fits in infancy. He had, however, suffered from lack of calcium and some bone trouble at the age of 8 to 9. But the limpness during the fits allowed one to exclude any tetanic manifestation that might have been in connection with a calcium deficiency. No signs of any organic lesion were to be found on neurological examination. All these points and, in addition, the fact that the attacks had occurred after his witnessing the hysterical manifestations of a cousin-sister, seemed to justify the diagnosis of hysterical fits.

During his first consultation, the boy was very evasive and would not admit any emotional problem. Only indirect methods, such as Thematic Apperception Test, disguised questions and drawing picture-stories, revealed his suppressed anger, but also his anxiety.

When asked, for instance, what he would do, if he were a powerful king, he described with lustful satisfaction, how he would put all bad subjects into prison,

flog them, bury them halfway in the ground and then send wild dogs after them. In his responses to the Thematic Apperception Test, the main themes were those of anger, quarrel, violence, robbery and an outlaw's life. At the same time, however, his stories reflected attachment to the mother, fear of displeasing her by being "bad" and of being left without her support. This struggle between rebellious tendencies and childlike dependence was even more neatly demonstrated in some picture-stories. In a first series, the story was told by the boy, while the doctor had to draw according to his instructions. We here give the text of the boy's tale translated into English :

"A mother duck and her ducklings go out for a swim. The black duckling (The patient himself is darkest in complexion in his family ! is fond of bathing, and he puts his head into the water. He likes it very much and this time dives into the lake. When he comes out, he finds that his mother and his fair brother have left him. He shouts for them, but the mother had left him on purpose. She did not love him, for he was black. He comes out of the lake and tries to run home. A cat that was hiding in the grass catches him and eats him." The moral of the story is : "If the duckling mother had been there and loved him, then, seeing the cat, she would have advised him to swim back." This little story allows interpretation on at least two levels: It first seems to betray some resentment about his having been sent away from the family. Children often experience a separation from the family, however "reasonable" and necessary it may be, as a sign of rejection and of punishment for "not being good". One can, however, also assume that both, the black and the fair duckling, represent him : one the docile, still childlike boy, the other one the young rebel. He cannot live the "black" part for fear of being abandoned by the mother, who only loved him as a "good boy". The solution is that he lets the "black boy" have his turn while consciousness and responsibility are switched off. Possibly one might even assume that the diving of the little duckling symbolized the fits of "diving into unconsciousness".

A next story, both told and illustrated by the boy, shows a similar conflict :

"A boy who lived near the river, went boating almost every evening. One day, the current of the water was not very favourable and he could not manage the oars, so that one of them slipped from his hand. Very soon, the other one also was gone. The boat was tossing up and down ; so he cried for help. But no help came in a hurry, and the boy was thrown into the river. But before he got drowned, his mother caught him. She had come in her boat and she brought him safely to land."

A further picture showed "a boat being rowed by two very weak men ; the occupant seems scared". The boy, indeed, did not seem to be master of his own boat, but driven by forces beyond him, with only very weak powers of control and direction which he could oppose against them. It looked, as if the early uprooting

from his village home for the sake of higher education, had exposed him so-to-speak "on high sea", without his being able to swim or row. Possibly his hysterical fits, apart from giving an outlet to his aggressive urges, had the purpose of alarming the family into keeping him at home. If this was his intention, he certainly got what he wanted ! The anxious mother insisted on his remaining with her. Though, as the family were convinced that he was possessed by a ghost, this meant his being subjected to all kinds of magic performances instead of getting "proper treatment" in the city, one may wonder, whether perhaps his being "rescued by the mother" was not the one move that would give him security !

As, with all his aggressive tendencies and his lack of conscious control, the boy seemed to be in great danger of some criminal deviation, we have included him amongst the "potential delinquents".

His history is an instructive example of the value of projective techniques in allowing a child to open up his problems without his having to identify too much with them. Though the two picture stories seem to reveal more than they conceal, the boy was hardly conscious that he was depicting his own situation. At the same time, this very proportion between revealing and concealing in the stories, seems to go parallel with the boy's choice of a hysterical symptom : his fits demonstrated his anger to others, while he himself not only could remain unaware of what happened, but also conveniently escaped responsibility, as everyone would blame "the ghost" who had taken possession of him.

(17) *Physical Defects* (Table XVI).—One would naturally expect that, in this functional group, the percentage of children with physical defects, in particular with signs of organic brain lesion and dysplastic stigmata, would remain behind the figures for the congenital and organic groups. The figures of 48.1 per cent for all physical defects, 20.4 per cent for organic brain-damage and only 5.5 per cent for malformations, confirm this expectation.

The main number of defects, in 11 boys and 3 girls, was of a generally physical type, such as weakness of eyesight or squinting, consequences of rheumatic heart diseases, rickets and other illnesses, states of endocrine dysbalance etc.

In a few children, the neurotic trouble for which they were brought, was a more or less acute reaction to a physical illness of recent onset. Weakness, helplessness, pain, perhaps slight confusion in fever, are factors that in themselves can provoke a sense of insecurity and lack of confidence. Beyond this, however, illness, taking one out of one's accustomed routine and distinguishing one from others who go about their usual work, can precipitate the experience of one's individual separateness and, if any thought of death is involved, also the limitation of all human existence. The intensity of such anxiety can even be heightened, if the child finds himself in unaccustomed surroundings, or if he has to face the threat of a permanent disability.

In two of our cases, experiences of this type are particularly obvious.

- (97) *Shafiq*, a Muslim boy of 15, was the son of a Hakeem. Though only aged 45, this father was already suffering from a degenerative disease of the nervous system, which reduced his capacity for work and which made him irritable and nervous. The mother, in spite of this doubtful future for the family, was pregnant with the 10th child. *Shafiq* was the 4th child and the 3rd son in the sibling-row.

His development up to 4 months before the first consultation was marked neither by any extraordinary outward events nor by any deviations in his behaviour. He was an average pupil, studying in 8th class at the time when we met him. He had clean, tidy habits and planned to become a doctor.

The only fact that may possibly be of importance, was that he had once been hit by a stone on his forehead. Whether it was some late consequence of this injury, which had left a boney scar, or some other cause that had led to ocular haemorrhage (an effusion of blood into the eye-ball) at the age of about $13\frac{1}{2}$, we do not know. At any rate, when we saw the boy, he had lost his eyesight almost completely. The threat of blindness had thrown him into deep anxiety and depression. He lost sleep, went into fits of weeping and demonstrated his inner restlessness by constant fiddling with his fingers. The parents, instead of calmly planning for his future by taking up contact with a blind-school while he still could see a little, were also helpless in their anxiety and unable to grant him any emotional support.

- (98) *Ishrat*, a Muslim girl of 7, daughter of a poor labourer, was presented at our Center, on advice of one of our former patients, only a few days after she had started an acute anxiety attack.

The small, thin, miserable looking girl, her face deeply marked by small-pox, which had also produced a scar on one cornea, was trembling with anxiety and clinging to her father with all her poor strength. Her heart was pounding loudly and rapidly above a stomach bloated with air.

The father gave us the following history : The child, third amongst 4, had lost her mother very early. The stepmother was rather strict. There seemed to be some evidence of jealousy with regard to the next-younger brother, a son of this stepmother. All these factors, however, though they may possibly have prepared the ground for later happenings, had not openly affected the child's development.

3 weeks before we met her, she had been admitted at Medical College for treatment against intestinal parasites. While first she seemed to be quite content there, she suddenly went into acute anxiety during the third week. She began to shout and weep, remained sleepless and maintained that a "black ghost" was

threatening to hold her. It is possible that the medication given against the worms, which even in stronger people can produce disturbances of vision and slight giddiness, had caused alarming physical sensations in the weak little girl. In addition, however, she had seen some patients dying in the same ward. The sensation of "blacking out" through the effect of the medicine may have been combined in her imagination with some tales she had heard of ghosts and graveyards. The case rather reminds one of Premi (83), who had also been in contact with the phenomenon of death and ghost stories.

When we examined Ishrat, she was scared of medication in any form, except for "sweet medicine". We had to think of a sedative that could be given as a sugary syrup. When a first dose of this mixture was administered by the doctor herself with reassuring talk and jokes, she regained confidence.

One little scene, which we happened to observe during one of the later visits, when she was a bit stronger, made us suspect that possibly some death wishes harboured against the little stepbrother, might have been mixed up in her reaction to seeing other children dying in the hospital. When the little brother, not very steady yet on his legs, stumbled and fell, Ishrat burst into triumphant laughter! This aspect, however, was probably of secondary importance. The other factors might have been quite sufficient in themselves to scare the weak little girl "out of her wits".

The parents were reasonable enough to bring the child for 4 interviews, until this acute reaction had been controlled with the help of sedatives, tranquilizers and roborants.

A few of the cases in which discrete neurological signs of brain-damage were found, have already been mentioned, *e.g.* Anil (81), Sohan (66), Premi (83), Rehman (76). In all these cases, and in a few others too, neither the children themselves nor the parents had known about the defect, so that the neurotic disturbance could not be regarded as a reaction against a consciously experienced handicap. It is, however quite possible that the pathological responses obtained on detailed physical examination may have corresponded to a general weakness of the nervous system, or in other words, an inadequate equipment for dealing with the stimuli of the outside world.

It may be interesting, in this connection, to remember that mind, in particular in its meaning of intellectual activity, is understood in traditional Indian philosophy to have a function of dividing and separating, in contrast to the "heart", which unites. Amongst modern Western writers, Aldous Huxley (28), perhaps under the influence of his study of Vedanta philosophy, has come to a similar conclusion, *i.e.* that the brain is not an organ that "produces" thought, impressions, sensations, but which, on the contrary, limits and insulates the individual against all the stimuli which would flood him, if he were left completely open to them.

One may usefully compare this concept with the arrangements for clear reception of one particular wavelength in a wireless set. As long as the system of tuning in is intact, purposeful listening is possible. When the devices for insulating and regulating break down, one is swamped by a chaos of sounds that no longer make any sense. Similarly, any defect in either the structures or the functions that mediate mental activity and, with it and through it, a logical, well-ordered grasp of the outside world, will reduce the ability to limit oneself, to concentrate and to resist. Perhaps, in this respect again, we can think in terms of a "sliding scale" of factors : On one hand, a defect in the physical channels themselves, which frustrates attempts at well-ordered communication with the outside world, though the fundamental willingness and need for this contact is there, a condition as we find it in organic psychosis and dementia ; on the other hand a faulty use of primarily intact channels due to an inherent weakness or reluctance against establishing these individual limits, which are at the same time also the means for rational communication with the "outside world". While extreme deviations either in the physical conditions for actualisation or in the particular mode of existence may by themselves determine certain disturbances of mental activity, organic and functional respectively, minor degrees of deviation of one type or the other, which alone might not produce any obvious disturbance, can lead to pathological manifestations, if combined with each other.

It would then be plausible that any slight weakness or lesion of the central nervous system, even if it is so discrete that it has passed unnoticed, would dispose a person to a neurotic or even psychotic reaction to stimuli and situations which would not disturb the balance of a person with intact nervous functions.

Reflections of this kind, though also applicable in our present context, *i.e.* the problem of neurotic children with discrete signs of brain-damage, will take on even more importance for what we have called the group of "infantile psychosis", in which the relatively high rate of slight organic defects in 43.8 per cent of the children, seems to confirm the views of some authors that infantile psychosis is a result of brain-damage.

(18) *Former Illness* (Table XVII).—While, as we have seen in the preceding paragraph, weakness or lesion of the central nervous system in particular may dispose to neurotic reactions, one can equally assume that any serious illness which reduces the ability to deal with the stimuli and demands of the outside world at any level, may call for neurotic defences. We have already seen that, in quite a number of the neurotic children, such manifestations as anxiety, depression, stammering, were first noted after a severe physical illness, or even acutely arose during some fever. An infectious illness always signifies a person's being overpowered, thrown out of balance, by some agent over which he cannot establish adequate control. According to modern bacteriological theories, it is not necessarily a lack of defence against the invading micro-organism that determines the intensity of the illness, but rather too violent a reaction of the human organism, which overshoots its aim and destroys itself. This, again, might be the physical expression of an existence tuned to mistrust, hostility and aggression. Seeing these

defences crumbling and defeated, either by the force of the enemy or by their own exaggerated action, will naturally in itself be an experience that shakes the foundations of one's security, by increasing one's suspicion against the harmfulness of the "outside world" and at the same time reducing confidence in one's own powers of resistance. One therefore need not wonder, if, after a severe illness, the "defence-front" is readjusted in a more rigid manner with the help of neurotic structures, even if the illness itself has not left any permanent physical damage.

As in any shocking experience, the degree of support which one can get during it from one's surroundings, if not from one's own inner resources, can decide to a considerable extent, how one will deal with it. If calm, patient and loving care and a spirit of encouragement sustain a patient during a physical illness, what he may retain of this experience may not be so much a shocking impression of helplessness and vulnerability, but, on the contrary, confidence in his own powers of overcoming difficulties and in the possibility that human love and care can carry one through them. A child may get scared by a gruesome ghost-story which he reads or hears alone in the dark, while the same story will only send a pleasant thrill through him, when he listens to it cuddled up in the mother's lap and in the homely light of a lamp or hearth-fire. Similarly, the effect of any terrifying human experience is determined by the amount of "shelter" available during it, no matter whether this shelter consists in mere human concern and help, or whether it has been found in an "eternal firm support and abode".

Here in India, this need for the support by one's nearest and dearest ones during phases of illness and crisis, is still realized far more than in the West, where personal concern has largely been replaced by "technical efficiency" and by the anonymous mutual assistance of insurances and collective health schemes. But, admirable as it may be to see a mother devote herself to her sick child and a father taking leave to assure the best treatment, these efforts will be of little use, if those on whom the patient has to depend in his weakness and anxiety, are themselves swept away by fear, overanxiousness and doubt !

If, amongst our neurotic patients, we have quite a number who have, *e.g.* gone through typhoid, (33.3 per cent), and if some of them showed definite signs of nervousness after the infection, it may not necessarily be the illness as such, in its physical aspect, that had weakened them, but possibly its psychological threat, which they may have had to undergo either in an atmosphere of overanxiousness or, on the contrary, without the sympathy and concern they would have needed.

That physical weakness as such can widen the gap between an eager mind and the motor instruments for its expression or make an already overstrained child still less able to come up to the high parental demands, has been shown by the 3 examples of stammerers,

of whom 2 dated the onset of symptoms immediately after an infectious illness, while the third one had been seriously handicapped by fevers in infancy.

The considerable number of children (7 out of 54) who had suffered from "liver trouble" in infancy and early childhood, again makes one wonder, whether this dysfunction and dystrophy of the liver also affects some of the centers in the brain stem which are known to have a particular affinity with liver-metabolism, or whether, on the contrary, both the physical disturbance of an organ meant for detoxication and assimilation, and the sensitivity that exposes to neurotic reactions may just be two different expressions of a fundamental inability to deal with the "outside world" by receiving it into oneself and making it one's own.

(19) *Education*.—Whereas for the congenital and organic groups, the tables on "Education" mainly had to indicate, how many children were left without schooling, in how many any attempts at formal education failed and how many were able to learn something, a similar table for the group of neurotic children, if it is to be of any interest, has to be more differentiated. We have divided the neurotic group into 3 age classes: 1 to 6 years, 6 to 12 years, 12 to 16 years. Furthermore, for all levels of educational attainment, we have separately indicated those children who were attending a class according to their age, the intellectually precocious or hard-pressed ones who had reached a standard above their age, and the retarded ones who sat in classes below their age. As a "normal base", we have assumed a start in first primary class at an age between 5 and 7. One will see from Table 19, that quite a few of the children, either through starting school prematurely or through getting double promotions, had reached classes in which they should normally have arrived at a higher age.

TABLE 19

Educational Standard of Neurotic Children.

	Aged 1—6 years			Aged 6—12 years			Aged 12—16 years			Grand Total
	M.	F.	T.	M.	F.	T.	M.	F.	T.	
No attempts at education	2	1	3	—	4	4	1	—	1	8
Teaching at home	—	—	—	—	1	1	2	1	3	4
1st—4th class, above age	—	—	—	1	—	1	—	—	—	1
1st—4th class, according to age	2	—	2	3	1	4	—	—	—	6
1st—4th class, below age	—	—	—	—	2	2	1	—	1	3
5th—8th class, above age	—	—	—	2	—	2	—	—	—	2
5th—8th class, according to age	—	—	—	2	—	2	3	3*	6	8
5th—8th class, below age	—	—	—	—	—	—	5	2*	7	7
9th—10th class, above age	—	—	—	—	—	—	1	3	4	4
9th—10th class, according to age	—	—	—	—	—	—	4	2	6	6
Intermediate above age	—	—	—	—	—	—	2	—	2	2
Intermediate according to age	—	—	—	—	—	—	2	1	3	3

* Two girls terminated school in 5th—8th class at a standard according to age, one girl at a standard below age.

If one comes from a country, where the age of school-entry is strictly regulated, and where physical and intellectual criteria of maturity are rigorously applied to any child whom the parents desire to send to school even a few days before he has completed his 6th year, one feels rather uncomfortable about the undue hurry with which some Indian parents rush their children into education. Often, of course, one hears the argument that the children themselves are eager and ambitious. But then it should be the task of their guardians to restrain this impatience, which often leads to nothing but an early exhaustion of abilities.

Far too much talk and often quite scaring warnings to the young are spent on the problem of controlling and saving up one's energies, where sex is concerned. But it looks, as if many people consistently overlooked the fact that sexual power only represents one particular sphere of human potential, and that the same ability for containing and retaining, which one recommends for sex, should actually comprehend all energies and talents of a young person. To spend oneself where it is easy, and for intellectually gifted boys or girls or even for those with only a good reproductive memory, the school-programme often hardly presents any difficulty,—and to avoid resistance, *e.g.* in the field of physical activity or moral courage, may create in a young person a quite unrealistic sense of omnipotence. This can be sadly unmasked, when, at a later stage, studies claim more attention and original effort, or when the rising powers of sex and aggression at the time of puberty demand ability to resist and contain.

The first symptom of adolescent trouble, neurotic or psychotic, is often "lack of concentration". With some embarrassment, the young patient may hint that this weakness is due to frequent "hand practice" or to "wet dreams". In some book on "Brahmacharya", he may have read the frightening stories about the many drops of blood that go into making one drop of semen and all the physical and mental evils that threaten those who wantonly spend this precious fluid. What they do not realize, is that both, their lack of continence with regard to sexual functions and their weakness of mental concentration, only betray a quite central and fundamental inability to limit themselves and to contain anything within these individual boundaries. A training to self-control in matters of sex will not succeed in remedying the situation just by saving precious body juices and tissues, but because this imposing of control is in itself a sign that the young person is still capable of mobilizing and developing forces that make for continence and for saving instead of ruthless spending.

To let a bright boy or girl fret impatiently in a class of his contemporaries to whom he feels superior, may of course not be a very healthy experience either. Wise teachers and parents, however, will know, how to keep the excessive energies and interests engaged in a manner that will teach the child or adolescent to stand resistance and to save up for later, what cannot be used to gain immediate triumph and appreciation.

We have seen examples of intellectually precocious children in Ajit (89) and Promod (70) and others who were driven by their parents against their inclinations in Anil (81)

who had to get up for his school-bus at 05.30 at the age of 3, Abu (95) who, at the age of 7, "never had time to play", Sohan (66) and Tajwar (73) who were sent to boarding-school prematurely and the little Anglo-Indian Kenneth (85), who would have preferred the fairyland of his imagination to the hard reality of school.

A powerful stimulus to effort, but also often a paralysing terror, is the system of frequent examinations. We have already seen examples of children who were driven into anxiety reactions on the approach of exams or into depression because of failure. One may remember Uma Shankar (69), in whom the anxiety attacks were coloured by "fear of exams", Sudha (91), who got puzzled during an exam and afterwards was in despair about having lost seniority with regard to her younger sister ; Farzana too (92) had her later phases of anxiety, after the age of 16, mainly at the time of exams.

While a great part of the apprehension in such "exam-reactions" may actually concern the outward situation itself, one can often guess a deeper note of anxiety about having one's maturity put to the test, for which the school examination is only a symbol. Not only in psychiatric patients, but also in healthy people, dreams in which they again find themselves in the examination hall, tinted with anxiety, are a quite frequent feature up to an advanced age. They betray a secret doubt about one's maturity, about one's readiness to engage wholeheartedly in the tasks and tests which life poses. Every exam is not only a formality which allows one to close a certain chapter of one's life, but it also opens a door to further regions. If the readiness for what lies ahead is not complete, if there is an immature, childish part trying to pull one back from future responsibilities, even the most perfect knowledge and phenomenal memory may not protect one from a failure, which this "backward" part cleverly arranges for its own benefit. Amongst our older adolescents, we have seen several who excelled or at least did moderately well in every exam that only led to further education in a sheltered atmosphere, while at the last threshold, which would have led out into the responsible life of an adult, they stumbled over their own emotional immaturity.

A particularly instructive example of the havoc exams can cause in immature pupils, is that of the Brahmin boy, whose father we have already quoted for his unreasonable, demanding attitude on page 69.

- (99) *Vivek* lost his mother, when he was aged 3. Already before his birth, she had been weakened by tuberculosis and depressed, as at that time the father was a political prisoner during Independence fights. Of 3 elder siblings, only one sister, one year older, had survived. These 2 children were brought up by the maternal grandparents, while the father, a fairly highly placed Government officer, started a new family with a third wife. *Vivek's* mother had already been the second wife. Though separated from the children most of the time and therefore unable to give them any fatherly love and concern, he still asserted his paternal rights, when it came to admonishing and urging them on in their studies. Once, in a fit of anger, he beat his son so much, that the 11 year old boy fell sick with fever.

The boy had been sent to school at 4. A double promotion to 7th class placed him at the same level with his elder sister, which stimulated mutual rivalry between the two siblings. After his initial success in getting the double promotion, Vivek fell behind his sister in the High School exam, where she secured better marks. Though, at the age of 12, he went through severe typhoid, he had, at the end of his 16th year, already terminated his second year of Intermediate. During the final exams, he could have easily passed in 2nd Division ; but he set himself the aim of getting a "first class". In order to make his success absolutely sure, he had written some science formulas on a small piece of paper, which he kept hidden in his clothes. His cheating was discovered, and he was severely warned. In spite of this he repeated his trick a second time and again was caught by the invigilator. When thus seeing the result of this exam all spoilt, he became so depressed that he tried to commit suicide by jumping into the river. The alarmed father brought him for consultation, entirely at a loss to understand why his son should resort to such unreasonable behaviour. He tried to deny that he had roused the boy's ambitions ; but his whole attitude, and in particular also his letter quoted earlier (page 73), betrayed that he had no understanding for the boy's emotional needs and that the only thing that interested him was to see his children shining in their studies.

The boy himself, small, delicate, with hardly any signs of physical maturity at almost 16, admitted that he himself had had the ambition of doing better than his elder sister. But he also pointed out that he had been scared by his father's disparaging remarks about a relative who had **not** worked hard enough for his exams and his occasional threats that he would **not** pay for further education, if he did not pass his Intermediate exam with Ist Division. Though he was quite aware that his cheating was wrong, any concern about using this illegal method had been motivated by fear of being caught more than by any genuine inward pangs of conscience. He simply seemed to have weighed the fear of being possibly discovered in his cheating against the fear of the father's certain wrath and displeasure, if he should have to face him with a mediocre result. One might call his way of acting a "short-circuit-reaction", *i.e.* a form of behaviour, usually under emotional stress, in which only a certain aim is kept in mind, while for the choice of any means to attain it, discrimination seems to be dimmed or even completely shut off. The boy's subsequent attempt at suicide showed how, in spite of his early attainments in the educational field, he had remained completely immature emotionally and morally. The father, as already mentioned, was deeply shocked by the boy's behaviour, which he obviously regarded as an insult to his fatherly pride. Instead of examining himself for his lack of true concern and affection, he accused an unlucky constellation in the boy's horoscope for having caused disaster at that moment.

Unless an adolescent has been pushed through his schooling in an undue hurry, as Vivek in the example just given, and Promod (70) mentioned earlier, he will, by the

time he is 16, not have reached educational standards yet, at which he has to prove his maturity by independent thinking and unguided effort. We therefore find more educational tragedies : failures in exams, choice of wrong branch of studies, loss of interest and concentration, in the age classes beyond 16. The few examples already found in this group of lower age, may, however, have shown, how important it is to adjust a child's upbringing not only to his speed of intellectual development, but to assure harmony between all spheres of growth : intellectual, physical, emotional, moral and spiritual.

One particular problem, which we have pointed out in Sudha's case (91), is that of the child or adolescent who grows beyond his parents in his intellectual achievements. While, on one hand, this may stimulate pride and triumph, it means, on the other hand, loss of parental shelter, and may even provoke guilt feelings. In a system of schooling, in which the contact between teachers and pupils can be rendered personal, and in which the teacher is free to direct his concern to the general human growth of the young people entrusted to him, the assurance of still having someone more powerful and wise beyond himself, may be preserved for the young student, even if he can no longer look up to the greater knowledge of his parents. Where, however, the teacher remains a remote, more or less automatic device for inculcating examination knowledge, even he may not be able to save from the sense of isolation and exposure, which a young person may experience in growing beyond those that ought to shelter him. The traditional Indian system of individual gurus with small groups of pupils, for whose development they assumed responsibility in every respect, gave an adolescent full scope for realizing his true self. The present system of mass education, substituting quantity for quality, has sadly deviated from this time-honoured ideal. While the traditional guru provided a real sphere of light, within which the pupil could discover the world and himself, the restricted concern of a modern teacher for his huge class, may perhaps be compared much rather to a cold, invisible electronic beam, that sets some calculating machine buzzing !

(20) *Problems of Adolescence*.—Special problems of puberty and adolescence have already been demonstrated and commented upon in several of the examples quoted. Instead of a theoretical repetition of much that has already been said, two further case-histories, of young patients whom we were able to help through their phases of crisis with all the means at our disposition and over a long period, are to be given:

(100) *Vimal's* history has already been quoted extensively in a paper entitled "Juvenile Rebels" (Hoch (24)). It gives, however, so typical a demonstration of the difficulties a young boy has to face on emerging from a sheltered, old-fashioned village-home into the rush of modern city-life, and of the various neurotic defences he can attempt, that we cannot resist summing it up again in this context.

The 15 year old Brahmin boy was brought from a village in U.P. by his father, a farmer and businessman, staunch supporter of Congress. In his village, as

well as in the neighbouring country-town, the father was a respected figure, who had held some high official functions. He had rather strict moral views and kept up his authority within the joint family according to old tradition. While he only lost his temper, when faced with some immoral or unjust act, the boy's mother got angry even about trifles.

Vimal had two younger and two elder sisters. As he was the only son, all the parents' hopes and ambitions had naturally been concentrated on him. The father wanted him to become a doctor and, already at the age of 15, after having passed his High School examination in the small country-town school, the boy was sent to Lucknow as a boarder in a big college. Vimal himself, who had a great sense of right and justice, would have preferred to become a lawyer. He was more interested in Arts than in Science ; but to please his father, he submitted his wishes.

One month after being admitted to the college, the boy began to write unhappy letters. He expressed his anxiety and doubts that, whatever he wrote, in his letters or even in his school-work, might be wrong. The boy's anxiety and worrying increased so much that he had to be taken home, where he remained dull and depressed, full of doubts about his own abilities. Finally, someone recommended our Center, and the boy was brought to us about 4 months after his start in college.

On examination, we found that the boy was obviously just going through a stage of intensive physical growth and transformation. He was very tall and would stick out in any gathering of his age-fellows. He had quite strong muscles ; but, chained to his own and his father's intellectual ambitions, he had not given himself the chance of developing and using his physical strength. In the rural school, there was no sufficient opportunity for games and sports and, having no practice, he did not want to expose his ignorance amongst his new comrades in the city. On neurological examination, we found some slight symptoms that suggested discrete organic brain-damage, as one sometimes finds it in patients who have epileptic fits. The history, which the boy himself gave willingly, made it appear probable that he may have had some minor fits, consisting just in a momentary black-out of consciousness. While he was under our observation, we never noted any phenomenon that was suspect of such "petitmal" fits. The symptom, however, about which the boy himself was worried, was his increasing doubt about "having written something wrong" in a letter or an examination paper. Our exploration revealed that this doubt did not concern any mistake in grammar or spelling, but the contents of what he had written. Gradually, as the boy gained confidence, he explained that, for the last few months, he had had some "bad" thoughts. Whenever he was writing anything, *e.g.*, when putting a letter into the letter box, he suddenly was tortured by the idea that he might have expressed one of these bad thoughts. At times he even feared that he might have scribbled something of the sort onto a rupee-note which he was handing over to a shopkeeper. Later, he

once explained that, at such moments, he also feared that he might be accused of having made false money.

In the first interview, Vimal told us about his unhappiness at this college, where the other boys called him "Dehati" and laughed about his lack of experience and city-manners. They also scared him by their traditional initiation-rites, to which every newcomer was subjected. While at home everyone knew and respected his father, he felt a stranger amongst his school-fellows and teachers in the city. He would have preferred to go to some other college in a smaller town, where one of his relatives was a teacher. The father, however, in his strict moral attitude, feared that this might expose the boy and his relative to the reproach of partiality. Being an obedient boy, Vimal could not go against his father's wishes ; but gradually he began to doubt his discrimination in sending him to an institution at which he had to suffer so much. It was only after several interviews that Vimal dared to reveal, what his bad thoughts were ; after already having had doubts about what is right and what is wrong for some time, he was deeply shocked, when hearing about the assassination of the Ceylonese Prime Minister in September of that year. He began to think that a similar thing might also happen to the President of India and, even worse, he began to imagine himself in the role of a rebel and murderer. When he discovered such thoughts within himself, he felt very much shocked and guilty.

He feared that other people might come to know about it. First, whenever he saw any piece of printed or written paper lying in the street, he had to pick it up and see, whether anything was written about him and his bad thoughts. Later, he began to doubt his own writing. He also had dreams about rebels, dacoits and murderers. For the young patient, who, similar to his father, had a rather strict moral attitude with regard to any wrong done by his comrades, it was a terrible shock to find that, within himself, there could be such rebellious thoughts. At the same time, though about this we could only gather some hints, the boy apparently had experienced his first sexual sensations and was also worried about these.

The psychological tests and further interviews, partly on an out-patient basis, partly while he was staying with us as an in-patient, revealed that the boy had obviously arrived at a very critical point of his development. He presented, as we have already shown, a multiplicity of various symptoms and one could not foresee yet, whether he might choose any one of them as his main defence or whether possibly he might even disintegrate into schizophrenic psychosis. The following main possibilities seemed to be open to him : He might gradually acknowledge the rebellious thoughts within himself, but at the same time be unable to accept them as normal features. This might throw him into deep depression and feelings of guilt and insufficiency. In some of his test responses, he indicated

a quite strong tendency towards suicide. Another solution, of which one finds first signs in his symptom of wondering, whether anything was mentioned about him in newspapers or any other written bit of paper, would have been to clear himself of any guilt, but to "project" the accusations into the outside world, to feel innocently persecuted, to build up a paranoid system. The same symptom could possibly also have been elaborated into a compulsion of controlling. Still another possibility would have been the complete suppression of any aggressive thought, of any animal instincts within himself. This, however, in this boy, who obviously, according to his physical constitution, needed an active outlet for his emotions, might have led to a dangerous internal congestion and ultimately to a disturbance of brain activity, i.e. to minor or even major epileptic fits. The slightly raised blood-pressure furthermore suggested the possibility of investing in a psychosomatic symptom in some other organ system.

Obviously the boy had been sent out into a wider world too soon and during a critical phase of physical and emotional development, at which he would have needed the protection of his accustomed surroundings and of paternal authority in a quite special measure. At the very time, when in his growth he was between boy and man, he also had to experience the transition from village to city, from old tradition to new forms of life, from dependence and obedience into self-reliance and own discrimination. No wonder, that he began to experience "doubts". Into this atmosphere of insecurity, in which probably resentment against his father's high expectations and his poor judgement in choosing a school must have been slowly growing, the news of the political murder in Ceylon burst like a spark into inflammable material. The hitherto dormant rebellious instincts were stimulated and threatened to overpower the internal moral authority. This authority, through strict and rigid, was not the boy's own yet, but just an automatic copy of an outward model, which, moreover, was beginning to lose its validity. When, after long acquaintance, the therapist dared to ask Vimal, what reason he could imagine for actually murdering a President, he promptly answered: "Because his administration is bad." It was too early yet to point out that he probably had some idea that his father's "administration" in his own case had been none too perfect and that, furthermore, his own inward "moral authority" was not quite adjusted to his needs and capacities.

While, in the beginning of his treatment, which was divided up into two main phases within a period of 5 months, anxiety and doubt were in the foreground, the relaxed and sheltered atmosphere of the ward, where no special duties and problems threatened him, brought out his fundamental inability to bear discomfort and difficulty and to keep discipline and self-control. This was particularly obvious, when we had to nurse him through an attack of mumps: he would complain in childish manner about the pain, but, on the other hand would not keep to the doctor's orders for strict rest. The fact that he developed all possible complications of this illness, may not only have been a consequence

of this lack of discipline, but possibly of his inward readiness to use any "material" for building up symptoms that might serve as a protection from the responsibilities of life. It was typical of the overanxious concern of the family for this only son, that they were moved by his complaints during this acute illness into breaking off his treatment prematurely. During one of the last interviews, Vimal admitted that he now realized that the struggle and doubt within him really concerned his hesitation to follow his own conscience, which at times urged him to go against convention and easy comfort. He did not lack insight into what was right, but, as he added with a note of defeat and resignation : "It is outside my strength".

Just as, in an earlier example, Amir (96) had managed to force through the easier path of returning into the shelter of his maternal home by his hysterical fits, Vimal succeeded in gaining his parents' consent to let him go the way that was not "outside his strength" : About 6 months after he had left the clinic, he came back, even taller and certainly more confident, reporting that he was now studying at the college, at which his brother-in-law was teaching and where he felt secure and respected. Apparently none of his many symptoms had frozen into a definite neurotic structure.

- (101) The second case is that of a girl, *Madhu*, also from rural surroundings, whose development we were able to follow closely over a period of $1\frac{1}{2}$ years. When the girl was first brought to us by her anxious parents, at the age of $15\frac{1}{2}$ we already knew some of her relatives: a paternal aunt, only a few years older than Madhu, had been under our treatment during a phase of acute schizophrenia with attempted suicide. We knew that another paternal aunt and uncle and the paternal great-grandfather had also been mentally ill. The father, a sturdy, good-natured farmer, seemed to be little differentiated and at times a bit dense and limited in his understanding and clumsy in his reactions. Though much more delicate and sensitive than either of the parents, our young patient was more attached to the father than to her mother, who was a short-tempered, stubborn, irritable and domineering woman. She had studied up to High School and, on one hand, had the ambition to see her daughter more educated ; on the other hand she seemed to grudge the girl her greater freedom at an age when she herself had already been tied down by adult duties. She seemed to prefer her elder child, a son, 2 years older than Madhu, and slightly more robust and confident than his sister. It may, however, be that this brother merely had managed to hide his conflicts more deeply ; some chronic digestive trouble showed all the signs of a psychosomatic disturbance.

After a normal delivery, the mother fell sick with malaria. The baby had to be fed on cow's milk and was mainly looked after by her grandmother. Quite early, she showed considerable stubbornness and, at times, went into violent

temper-tantrums. When she refused food, the father would force her to eat out of consideration for him, by his going on fast. Up to the age of about 6, she continued to wet her bed.

At the age of 6, she was admitted to the village school. After her High School exam, she followed her brother to a neighbouring town. As there was no hostel accommodation available for her, and as the brother needed special care for his weak digestion, the mother accompanied the two children, while the father had to remain on the farm with the rest of the joint family.

In this restricted atmosphere of a town-flat, which the mother, used to rule on a big farm, obviously resented, clashes between the sensitive adolescent girl and her more robust mother were unavoidable. The mother would watch in possessive manner over the children's movements, always trying to keep them from contact with other people. In front of others, she would promise their taking part in some outing ; later she would take back her promise and prevent them from joining their comrades. Though Madhu was very fond of her father, she could not forgive him for not standing up more energetically against his wife. She further resented that the only way which both parents knew for showing their love and concern, was to shower the children with material comfort and luxuries, while neither had any understanding for their emotional needs. Nevertheless, the girl very cleverly knew, how to take advantage of this very tendency, to get all her wishes fulfilled almost as soon as they were expressed. Accepting this generosity, on the other hand, again created guilt-feelings in her for not thinking more kindly of the parents who were doing so much for her.

Already at the age of 11, Madhu had started menstruating. She had some vague notions about sex and the reproductive functions, gleaned from the discussions of her more precocious classmates ; but she had never discussed such matters with her mother, who kept an old-fashioned attitude of reserve and inhibition. On the whole, Madhu rather seemed to rebel against the idea that one day she might have to fulfil the duties of a housewife and to bear children. It took a long time, until she accepted the opportunity of getting some adequate information about the whole sphere of sex from the psychotherapist.

While the material pampering had rendered her unable to bear any frustration and to resist any outward influence, the lack of understanding by the parents, who were of different nature, and her growing beyond them intellectually, exposed her to becoming conscious of herself as a separate and responsible agent at a time, when she was in no way ready to accept this burden. Once, during the treatment, she exclaimed quite emphatically : "I do not want to become conscious of myself !"

The final scene which provoked the alarming symptoms, happened shortly after the first Intermediate exam : Thinking that she had earned some rest after her last-minute efforts for the exam, she burst into anger, when the mother interrupted her idle loitering by asking her to do some housework. This led to a heated dispute, during which the mother uttered the curse that the girl should never have been born. After this clash, Madhu began to feel anxious and depressed. She lost appetite, felt a "lump in her throat", nausea, palpitations, tingling in her limbs, giddiness and a sensation of emptiness in her head. Often she would even vomit her food. At times she was obsessed by the fear of going mad, and once the mother caught her on the point of attempting suicide by pouring kerosene oil over her body with the intention of burning herself. The young girl was brought for consultation, after these symptoms had already continued for 3 weeks. The parents, in their helplessness, were glad to accept our offer of keeping her as an in-patient, and Madhu herself was relieved to escape from their anxiousness and to remain in a place where she could find some understanding for her conflict.

During frequent interviews over a period of 3 months, we gained considerable insight into her problems. In the beginning, she had great difficulty in expressing herself, not so much perhaps because she was reluctant to expose her parents' weaknesses, but rather because she had not grown sufficiently aware of herself to register more than a vague discomfort that could not be committed to the precision of words. Gradually we discovered that she had a quite vivid imagination with a tendency to personify and dramatize inward fears and conflicts. She would, for instance, tell that "Yamraj" wanted to come and take her away. She could see his shape and hear his voice, telling her that she must die. At times she felt that she had no hands, no feet, no mouth. This hysterical denial of the main organs that are used for conscious action, probably without her being aware of it, also slipped into her drawing of a self-portrait : The human figure had no mouth, no hands and no feet.

This is a feature which we had also found in drawings of other Indian patients who wanted to escape from the responsibility of being an "agent". Rather characteristically, for instance, Vimal (100) whose case-history we have just given, also drew his portrait without hands and feet. The author remembers having made similar observations in delinquent adolescents in Switzerland. One realizes, how close the mere representation in a drawing and the sensations which this girl described, already come to fully developed hysterical symptoms of loss of speech or paralysis of a limb !

In order to help Madhu to recognize as her own what belonged to her, and to give her a chance of ventilating her anger and resentment against the mother, we encouraged her to stage dramatic scenes. At times, she would play her own part, at times that of the mother as she actually was or as she would have liked her to be, while the therapist provided the role of the corresponding partner. By varying the emotional tone of these scenes and by gradually giving them a more

happy and harmonious ending, the girl could experience that, what had happened, need not necessarily be a rigid pattern that would have to repeat itself in future. While, at first, she was very shy and reluctant, leaving most of the initiative to the therapist, but obviously getting some relief even through this vicarious experience, she gradually became more bold, allowing herself even to enter into a "symbolic execution" of a picture of the "bad" mother and suggesting, as a retaliation for the mother's curses that she, the mother, should be reborn as a tiger or an elephant in her next life. She also invented stories of poor neglected children who go to the jungle, because they are fed up with their mothers. This story, which one finds frequently, not only in children's phantasies, but also in traditional fairytales, may point to the great amount of spite and wish of punishing the parents which is often invested in the formation of neurotic symptoms, meant to alarm and worry parents.

Madhu also revealed that her mother had destroyed much of her self-confidence by giving her the idea that she had neither beauty nor charm. Actually, at the time when the girl came to our Center, she was at a rather awkward stage of development, and her dark, sullen and angry facial expression hardly contributed to make her look attractive. During the 3 months which she spent at our Center, however, she began to bloom into a pretty, graceful young girl. This development brought up new complications : Some young male fellow patients were attracted by this emerging feminine charm and started swarming round her. As she was not conscious of herself yet in this new role, she hardly seemed to notice what was going on. Her responsibilities for this new aspect in her life were "brought home to her" by some "visions", or perhaps one should even call them hallucinations !—of faces of men looking at her angrily. We had to explain to her that, taking care of her awakening femininity was another task she had to face and that, by carelessly and unconsciously spilling her charms all over the place, she could actually annoy or even enrage men.

Gradually, she began to realize that her anger was not so much directed against the mother or any other person, but far more against the rising of her own conscience. The part that was ready to grow up, resented the pampered child that stood in its way, while the latter rebelled against the necessity of having to assume responsibility. She admitted that she wanted to grow up where freedom and rights were concerned, but that, with regard to work and responsibility, she preferred to remain "small". This realisation of herself as the source of the anger was expressed in a changed character of the "visions" : She now no longer saw other people, *e.g.* Yamraj or "the men" staring at her angrily, but she would see her own face, reflecting whatever mood she happened to be in. At the same time, she began to see, where she had been at fault in the unhappy relationship with her mother. On the other hand, she felt the lack of shelter by parents who were facing the new age helplessly. She realized that her idea of committing suicide really had had the purpose of punishing her parents for not understanding her.

By the time the new term started, she felt ready to go to school again, though the news of her having failed in the exam in April had added shame and disappointment to her other difficulties. After a "false start", which ended in her coming back to the shelter of the Center for a few days, she finally had the courage to face college-life. The domestic arrangements had meanwhile been changed, so as to avoid close friction between mother and daughter for some time. The brother was to stay at a hostel, while Madhu was placed with relatives. During the following year, we kept up correspondence, not only with the girl herself, but also with her parents. From time to time, particularly during menstrual periods or before any exam, she still lost control, going into fits of anger, vomiting, talking of suicide or of Yamraj coming after her, complaining of various physical signs of anxiety. At such moments, she was occasionally brought for interviews.

When we first met the girl, she presented a great multiplicity of symptoms : anxiety, conversion symptoms, hysterical tendencies, depression, slight paranoid trends. Later it looked, as if some of her anxiety were going to be crystallized in what one might call a "phobia" or an obsessive fear : She began to suspect and fear that some dish that was being cooked might have been poisoned by a lizard that could have fallen into it from the ceiling. As this symptom corresponded to the popular belief that "chipkalis" are poisonous, one can assume that its formation marked a stage at which the neurotic tension could be accommodated in a relatively small and insignificant area that left other spheres of life undisturbed. From time to time, she would still relive, in vivid dreams, one of the critical scenes, *e.g.* the mother's anger or her own attempts at suicide.

What became more and more obvious during the $1\frac{1}{2}$ years of observation, was,—just as in the preceding case of Vimal (100),—a fundamental reluctance against facing any difficulties and making any effort. This "laziness" even made her gradually reduce her high educational ambitions and regard with more favour the possibility of simply "settling down" soon in a quite conventional marriage. The parents, in particular the father, with whom both doctor and social worker spent a lot of time, gradually also learned to hold back their unreflected reactions and to think more of the real and permanent welfare of their children.

While for these two Hindu adolescents, the period of puberty brought a widening of their life spheres, a bursting of boundaries, which left them exposed and unprotected, this same age, in more orthodox homes, is still frequently marked by severe restrictions. Not only girls have to keep apart from male family members and modestly cast down their eyes, but boys too are still instructed that they should under no circumstances look at a woman. One can imagine, what conflicts can arise in a young person, if at home he or she is taught such extreme modesty and shamefulness with regard to the other sex, while, outside the family, one meets a world in which the free mixing of the sexes becomes more

and more customary, and in which the exciting charms of film-actresses and heroes are glaringly advertised from posters, newspapers and loudspeakers !

The transition from the freedom of a child who need not make any distinction between male and female family members and the adolescent who has to avoid the other sex "like poison", is perhaps most marked in the traditional Muslim family setting.

The young Hindu still has the defence of converting any relationship into harmlessness by calling a girl "his sister" ; amongst Muslims, where marriages within the family are common, probably even this way out could not remove threat and temptation. We have already given some examples of Muslim girls who almost broke down completely at the time when they had to enter purdah. One more example of the way a Muslim girl experienced this restricting change in her life, may illustrate this situation :

- (102) *Nur-us-sah*, aged 14, daughter of a zamindar, was brought because of "fits of fainting" and depression. She had grown up in the country-home of the joint family. Being the eldest of 6 children, of whom only the two youngest were boys, she had been pampered up to the age of 11, when the first brother was born. He naturally claimed the interest of the family ; so *Nur-us-sah* got somewhat neglected.

She had only been sent to school up to the age of 10 and had reached 5th class. At the age of 13, she started menstruating, an event which rather upset her and which she tried to hide from her mother, as she thought it was something abnormal. Though she had to keep "purdah" since the age of 10, she still had a certain freedom for playing with her friends, as long as the family remained in the village. When she was 14, however, probably with a view to better chances for a marriage, she was taken to a town. There, she bitterly missed the company of her playmates and the chances of running about in the open air. She was scared by the prospects of an early marriage and stubbornly refused to cooperate in any such scheme. One day, during the festivities for a cousin's marriage, which probably heightened the girl's preoccupation with her own future, the family went for an outing to a park in the city. There, the girl suddenly felt palpitations, pain in her stomach and then became "unconscious", with limbs stiff and teeth clenched. These fits, probably with a tetanic component due to excessive anxious breathing, repeated themselves during the following months.

When we examined her, 5 months after the first fit, she was depressed, shy, reluctant to expose herself. She admitted, however, that the restrictions imposed on her, already though her entering purdah at 10 and then even more by life in the city, had been very oppressing. The first fit, quite significantly, happened, while she was watching some caged birds during the visit to the park ! She could readily see the likeness of her own situation to that of these little creatures deprived of their natural freedom.

While prospects of an early marriage were frightening several of the girls in the neurotic group, the girls who actually got married before the age of 16, are all to be found amongst the psychotic adolescents. The only married adolescent in the neurotic group is Jagdish (72). His wife had not joined him yet. It is possible that his depression and his hypochondriac symptoms had to demonstrate to the family, that he was not ready yet for the responsibility of a family.

Keeping young people out of temptation or to provide them with legitimate satisfaction of their sexual needs by early marriage, is one way of helping them to deal with the rising energies of puberty age. This method, however, could only serve in a social order which, even at an adult age, through its customs, rites and taboos, protected them from opportunities that might have put their resistance to the test. Once these outward restrictions have been abolished, unless wanton licence and irresponsible succumbing to any chance are to rule the lives of the young, the only way open is to establish and strengthen the boundaries of individual consciousness and control. This, however, is a task which many young people find too exacting. Like Vimal (100), they may admit: "This is beyond my strength" or, like Madhu (101), they may stubbornly rebel: "I do not want to become conscious of myself." Where no rigid social customs any longer protect from contacts and experiences against which young people are not ready to stand up in individual responsibility, only the personal concern and guidance of some mature adult can hold them together and give them a model for developing their own inner firmness. If parents and teachers fail in this task, psychotherapy can fill this function in some cases; the opportunities for such individual care, however, are still scarce, not only within the framework of psychiatric clinics, but also in the form of student counselling and psychological services.

(21) *The Children's Interests.*—Special interests were indicated by 79.6 per cent of the neurotic children. As, naturally, the interests will vary according to age, we are giving their distribution again for 3 age groups of 1 to 6, 6 to 12 and 12 to 16 years. (Table 20). One will see that, in comparison with the groups with congenital and or-

TABLE 20
Interests of Neurotic Children.

	Aged 1—6			Aged 6—12			Aged 12—16			Grand Total
	M.	F.	T.	M.	F.	T.	M.	F.	T.	
No interest indicated	1	1	2	—	5	5	3	1	4	11
Motor activity, sports	—	—	—	3	—	3	7	1	8	11
Machines, vehicles	1	—	1	2	—	2	1	—	1	4
Fine clothes	—	—	—	—	—	—	1	1	2	2
Good food	—	—	—	—	—	—	1	—	1	1
Music, dancing	—	—	—	1	2	3	2	2	4	7
Noise	—	—	—	—	—	—	—	—	—	—
Playing with water or mud	—	—	—	—	—	—	—	—	—	—
Manual occupation	1	—	1	2	1	3	1	5	6	10
Cinema	—	—	—	1	—	1	6	1	7	8
Toys, playing	1	—	1	4	—	4	5	—	5	10
Animals	—	—	—	—	—	—	1	—	1	1
Intellectual activity	—	—	—	5	—	5	10	4	14	19

ganic disturbances, the more constructive and in particular also the intellectual pursuits, play a greater role. Passive indulgences, like those for good food, fine clothes and cinema, however, seem to indicate that young people are not sufficiently encouraged to gain pleasure and a sense of achievement by exercising and developing their own abilities, but that many of them would rather enjoy what others supply for them ready-made.

As we pointed out earlier, in the paragraph on education, it may be far better to direct the energies of a gifted child or adolescent into various channels, amongst them some that will offer resistance to his natural abilities, than to let him or her spend all strength in racing ahead on the road that is easiest, to a level far beyond the actual age.

In this respect, youth movements, as *e.g.* Boy Scouts and Girl Guides, NCC and other organisations, which encourage to organized activity, to pioneering and inventive enterprise, to endurance and discipline, all in a spirit of helpfulness and social responsibility, can render very valuable services. Recreational centers and parks, where children find guidance and supervision in games and hobbies, can also give great encouragement in spending time and energies in a constructive manner.

(22) *Number of Visits and Possibilities of Treatment* (Graphs VIII and IX).—The graphs illustrating the number of visits and the results of treatment present a far more optimistic picture than for any of the previously discussed groups. Only 33.3 per cent of the patients dropped out after one single consultation, and 11.1 per cent of the children were allowed to profit by prolonged treatment, either by more than 10 out-patient visits or during a period as in-patients.

Amongst those who came for more than one consultation, however, there were quite a number who did not keep up their visits to a point at which a result could have been evaluated. The cases in which we had no information, together with the two in which no improvement could be stated with the method tried (which does not necessarily mean that our resources were exhausted, but only that the parents' patience and interest failed !), therefore amount to 62.9 per cent, leaving only a minority of 37.1 per cent who presented any degree of improvement. These results may look disappointing. If, however, we consider that even the cases in which we were not given any chance of helping, contributed to our gaining experience, which now may prove of value to others, our efforts were certainly not in vain.

As neurotic reactions and in particular neurotic developments of long standing consist in distortions of growth, one can never hope to effect a "cure" by any simple and immediate method. The spectacular disappearance of particular symptoms, especially those of hysterical type, which can sometimes be achieved by suggestive methods, such as hypnosis, narco-analysis or the "magic" performances of non-medical healers and fakirs, give no guarantee for a smooth further course. They may remove the outward sign, but rarely touch the root of the trouble.

The neurotic conflict is often one between the need to establish adaptation to and dependence on one's surroundings and, on the other hand, the urge to realisation of one's very own possibilities. Treatment can, therefore, as a matter of principle, envisage 3 main aims : The easiest one, already mentioned just above, is simply to abolish the symptom and to leave the conflict alone, perhaps to be converted into a different symptom or to "hang in the air", until a future experience again precipitates it into a manifest disturbance. The second road, which would be mainly that of mere medication or also of the suggestive and supportive psychotherapeutic methods, would be to confirm the patient in his need for adjustment to the social framework and support by his surroundings. This can be done either by persuading the patient to accept his lot, or by helping him to find more economic and favourable solutions of his problems or, particularly in the case of small children, by influencing the persons of his immediate surroundings, above all the parents, so that they will provide better conditions for growth.

The third aim would be to help the patient to become himself, to make all his possibilities his own and then to act no longer out of necessity and compulsion, but out of free choice and loving concern for his fellow human beings. This, however, may mean that the therapist has to accompany a young patient through years of his life, possibly through critical phases of rebellion or threatening disintegration. It means that he has to devote himself to the patient with a never failing interest and concern, that puts aside all personal considerations, so as to be only there for the patient, as the sphere of light within which he can discover himself, and the playground on which he can try out his emerging possibilities. One will realize that opportunities of this kind are limited not only by lack of trained therapists, but also by the reluctance of patients to invest so much time, money and personal effort in a therapeutic procedure. Where young people are concerned, not only the patient's readiness counts, but he may depend on his parents' consent from a financial point of view, and also with regard to their willingness to let the child develop according to his own nature, which may lead him away from the aims and ideals they have planned for him. Furthermore, not every person can go this way of self-realisation, which may be "beyond his strength". Some people, probably the majority, are destined to remain sheltered and contained within the solid framework of a social structure. Danger and insecurity threaten for them, when this support slackens or is revealed as treacherous. The only solution for them lies in being led back to and confirmed in these outward supports, to achieve, what one calls a "social remission".

In others, on the contrary, the urge to leave the common road and to pursue the untrodden path of self-realisation is so strong, that any attempt at keeping or pushing them back onto the beaten track will result in agony and conflict. These may be the ones who can be helped to grow through prolonged deep psychotherapy. Again, however, one has to be sure that their straining against the fetters of convention is not only directed at gaining freedom "from" something, *e.g.* from parental control, from responsibility, from frustration, but that there is also strength and determination to use

this freedom "for" something ; for responsible choice, for commitment to the cause of truth, for continued growth, against all the temptations of settling down in comfort and ease.

To discriminate, where the conditions for such individual growth are present, and where, on the contrary, only the safe limits of conventional life can guarantee sufficient support to a weak existence, is one of the most delicate tasks and greatest responsibilities of a psychotherapist.

A few examples of children and adolescents, whom we were able to accompany at least on a short stretch of their way, with supportive measures as well as with opportunities for unfolding their own potentials, have been given. We have tried, in reporting these case histories, to convey some idea of the methods used. No general recipe can be indicated. Insight into the problems and concern for the needs of each individual child have to show the way by which help can be given.

(23) *Conclusion.*—In concluding this important and extensive chapter on neurotic manifestations in the children examined by us, we want to stress once more that our experience can by no means be considered as covering the whole range of emotional distortions to be met in children and adolescents in present-day India, nor as giving a representative sample of the possible syndromes. What our observations can indicate, is merely that neurotic reactions to certain situations within and outside the Indian family do occur and that a number of parents not only recognize them, but also are seeking suitable help. It therefore should be worthwhile to provide more and more special services equipped to deal with the problems of these children and their parents.

7. *Psychophysical Infantilism.*

(a) *Definition, Differential Diagnosis.*—The small group of 6 children whom we have placed in this separate group of "psychophysical infantilism" or "infantilism" for short, perhaps does not entirely deserve to be dealt with in the "functional" section. In all children, the disturbed development also expressed itself in physical features : either a general retardation of growth or a defect in one particular organ system, in 2 of them even in signs of organic brain-damage. The mental and emotional retardation therefore cannot be regarded as a mere psychogenic disturbance in the function of originally intact organs and channels ; on the other hand, the slowing up of development cannot be called "organic" in a strict sense either, as, —except perhaps to a certain degree in the 2 cases with discrete neurological symptoms, —it is not the direct and specific outcome of a structural defect of the nervous system. Furthermore, one knows that in typical cases of this kind, where physical, mental and emotional development are equally retarded, it is not so much the potential for growth as such that is lacking, but rather the speed of its actualisation that is inhibited. If given enough time and

favourable conditions, children of this type can "catch up" and reach a more or less average grown-up level, though possibly at a much later age than one would normally expect.

The retardation can be a quite general and uniform one, affecting the total growth, so that, in every respect, the child simply impresses one as considerably younger than his age. As, however, a chain is only as strong as its weakest link, some particular deficiency, for instance in the circulatory system, the digestive organs or the hormonal glands, may equally be able to hold up general development. A congenital malformation of the heart or the big blood vessels, for instance, may provide an insufficient supply of freshly oxygenated blood to the vital organs ; a digestive deficiency may prevent the nourishment of body tissues with the necessary substance, while a hormonal disequilibrium may result in lack of coordination in metabolic processes.

Again, one will probably do best to regard the problem from a total psychosomatic point of view and to define psychophysical infantilism as a form of existence with reduced speed of maturation. In the individual case, it may be more the fundamental constitution of the child which determines slow ripening, even without any particular physical or environmental obstacle ; or the outward conditions for realisation, either in the form of a physical weakness or possibly of unfavourable influences from the surroundings, may impose a check on the development of originally average potentials.

Perhaps a comparison with the growth of plants may make the issue clear : A farmer will know that certain plants, by a slight variation in their nature, need more time to produce a crop than others of the same species. He even takes account of this peculiarity to keep his harvest "staggered". On the other hand, the time at which a tree or other plant will bear fruit, also depends on the quality of the soil, on atmospheric conditions and on the care that is spent on attending to it. Furthermore, any farmer or gardener will be aware of the importance of choosing the appropriate time for any performance, such as sowing, thinning out, transplanting, grafting, pruning, watering, manuring. A seed sown at the wrong time, a young plant exposed to an unsuitable climate, a tree deprived of its young shoots or transplanted out of season, no matter how healthy and promising they may have been initially, will be stunted in their growth.

Human development too, already in the embryonal period, but also after birth, has an inherent rhythm and sequence. Any potential that is provoked into premature development or, on the contrary, checked or suppressed at the point of its emerging, may lose its natural vigour. One knows that at each period of embryonal life, some particular organ or function is about to evolve from mere potential into actual formation. Harmful influences during pregnancy will therefore differ in their results according to the phase of development at which they affect the embryo. The same is true even in postnatal life : At the moment of birth, the organism is not fully fashioned yet. The nervous fibres, in particular, only gain, some time after birth, the insulating sheaths,

which permit distinct channelisation of sense impressions and impulses. The same postnatal damage, *e.g.* brain injury or encephalitis, will determine different symptoms according to the stage of development at which it hits the nervous tissue. Careful study of the neurological symptoms can even allow what is called "developmental diagnosis", *i.e.* to determine retrospectively, at what particular phase growth was disturbed. What may be true for any gross damage to the nervous system or the organism in general, also applies to more subtle premature stimulation and exploitation of a particular function. We have pointed out, in the preceding chapter, that children who are urged into premature intellectual development, often exhaust their abilities before time and are unable to bring them to true fruition.

Such processes of inhibition of development, perhaps occurring at decisive moments, when any damage, either directly or through one of the vital organs, can affect the organism as a whole, may be responsible for what we can call psychophysical infantilism.

The few cases which we have summed up under this heading can therefore be differentiated from the other diagnostic categories by the following criteria : From oligophrenia, they are distinguished by the fact that the retardation is a general one, affecting physical, intellectual and emotional growth uniformly, and that it does not seem to be due to lack of potential, but only an altered speed and rhythm of actualisation. The distinction between infantilism on one hand and postencephalitic states, epilepsy and other organic states on the other, is an obvious one, either from the aetiological or a symptomatic point of view. Against the developments and reactions we have described as neurotic, this small group again is set off by the universality of retardation. Unlike the neurotic child, in whom a deviation from his own behaviour at an earlier period can be stated, or in whom more advanced tendencies struggle against undeveloped or regressed parts of the personality, the infantile child does not really deviate from himself, but only from the norm for his age ; nor does he present any significant contrasts between unequally developed parts within himself. Development as a whole is simply slowed up right from the start, or sometimes after a severe illness in early infancy. Of course, as we have already mentioned in the chapter on neurosis, this general retardation may expose the child to environmental influences that affect this relative harmony secondarily, *e.g.* the overdemanding attitude of parents, sibling rivalry or, quite generally, anything that goes against the child's need for ample time to develop. On the other hand, we have seen that infantile features can be partially retained or resorted back to in the course of neurotic development. In the small group of infantilism, we have tried to assemble only cases in which the relative harmony of a universal slowing up has been more or less preserved. Some of the children, however, may perhaps already show signs of a secondary distortion. In particular, we find, in 3 out of the 6 children, autistic features that made us hesitate, whether they had not better be classified in the group of infantile psychosis. What made us keep these cases in the group of "infantilism" in spite of the presence of schizoid tendencies, was not only the sporadic and mild nature of such symptoms, but the impression of a universal

retardation and,—last but not least!—the relative ease and confidence with which these children accepted or even actively sought human contact and communication. Furthermore, the 2 groups, each as a whole, present certain characteristic differences, *e.g.*, with regard to heredity and disturbances of pregnancy and delivery. We can, however, not exclude that there may possibly be a continuous range of transitional stages from cases that present the universal retardation in a pure form, to others in which either a particularly inadequate constitution or unfavourable environmental factors have not only led to neurotic distortion, but to a psychotic disturbance. Where the line is to be drawn between the two, will probably always be a matter of the subjective view of the observer.

This “view of the observer” must not be understood in a merely technical and theoretical sense of looking at a well-defined phenomenon from a different angle and with a different scale of values and measurement, but it has its deeper implications: Even physicists nowadays know that the approach of the observer, or what one calls his “personal equation”, determines, in which way any phenomenon (and “phenomenon,” from Greek “*phainomai*” already signifies “that which appears”!) will reveal itself. If this is true even for inert matter, it ought to apply all the more to any living being. If different psychiatrists arrive at different diagnostic labels on examining one and the same “case”, this may not necessarily reflect the different textbooks they have read and the different “schools” they adhere to, but is mainly the result of the way in which the patient discloses himself to and in the particular lighting sphere of consciousness which is brought to shine on him. Psychiatrists all over the world know, how difficult it is to be at the same time a discriminating diagnostician and an understanding and accepting therapist! The more one allows the patient to be and become himself in the permissive atmosphere of the psychotherapeutic “playground”, the less will one have an opportunity for noting pathological symptoms which, in presence of a less accepting and more demanding observer, would still be grossly manifested. If one allows even a severe schizophrenic to disclose himself on the childlike level to which his least developed possibilities can reach up, many, if not all, of his symptoms will vanish, though of course only as long as he is sheltered in this “life-giving” atmosphere, as one of our older adolescent patients called it. A patient may even present himself quite differently to one and the same particular observer at various stages of the relationship. When one first meets a patient, no matter whether a child or an adult, one usually has to play the role of the critical investigator, perhaps also, at least partly, the advocate of the relatives or the agency who have had reason to complain about his behaviour. The glaring searchlight of this inquiring attention, which measures the patient, with the implicit demand that he really ought to come up to some expected standard, will necessarily make him “close up” and hide behind his sick defences. If, however, perhaps after psychotherapy has been decided upon, the same psychiatrist approaches this same patient as some one whom he fundamentally regards as a human being in his own right and who deserves his respect, concern and love, he may be welcomed by a quite different openness. It even seems that, without any particular “switching on” of one or the other attitude by the psychiatrist, in fact before any ex-

plicit contact has been established, a patient may "sense" the possibility of being accepted as he is and therefore drop his defences right from the start.

The author remembers a particularly impressive example of this kind : An unmarried female Hindu patient, aged about 27, was brought for admission after several years of illness and previous treatment at a closed mental hospital. The case-history, given by the relatives in writing before the consultation, indicated schizophrenia with catatonic and paranoid features. While passing through the waiting room on some other errand, the author saw the new patient sitting there : the picture of a rigid, bitter and suspicious chronic "back-ward patient" ! Nothing more than a casual "namaste" and perhaps an encouraging smile was addressed to her. When, about half an hour later, the author approached the girl to ask her to her consulting-room, she could hardly trust her eyes ! Instead of the closed-up, hostile front, she found a wide-eyed, innocently smiling child !—the same patient, but magically transformed through the possibility, which she had intuitively grasped, that someone might accept her as the child which she still was. Out of this encounter, a fruitful therapeutic relationship developed.

To come back to our small group of children classified as "infantile" and its delimitation against the group of "infantile psychosis", one may now understand that the distinction cannot always be made on a purely objective level. Where a child who, either by his general constitution or by some particular physical weakness, has been retarded in his development, is accepted at his "real age", instead of being expected to come up to the level of his "chronological age", he may simply show himself as the baby he actually is. Where, however, he has to defend himself against excessive demands and lack of understanding, neurotic or even psychotic symptoms may dominate the picture. The persistence of such symptoms even in the presence of an accepting therapist, may then depend on the degree of flexibility which this defence still has and, of course, on the quality and duration of the relationship that develops. As, in a child, a defensive attitude may not have had time to become so rigidly fixed as in an adult chronic patient and as, furthermore, it is much easier to accept a child as a "baby" than to see a small child in an adult, the autistic attitude can often be more easily overcome in children. The approach of the psychiatrist, according to its more diagnostic-scientific or therapeutic-humanistic colouring, may also explain the widely varying views which different authors have about the nature and incidence of infantile autism and childhood psychosis.

Autistic withdrawal, schizoid tendencies,—both terms that indicate an attempt at cutting oneself off from communication and at achieving a kind of self-sufficiency,—seem to stand in the service of self-protection against being exploited, but also against being "invaded" or "poisoned" by "influences" with which one cannot deal in one's immaturity. In a situation in which nothing is demanded from one and nothing forced on one,—and the true psychotherapeutic atmosphere ought to be thus characterized!—the defences can be allowed to fall, unless they have become so rigid that the patient no longer holds them, but that they control him.

One can therefore imagine that, if a child's capacity for maturation is in any way hampered, parental attitude may be decisive in either allowing the child to live at the level he can afford or in driving him into an autistic defence. It may be characteristic that those children in our "infantile" group who showed autistic features, had been exposed to the very attitudes which we find most frequently represented in the parents of the psychotic children ! The fact that the group of "infantile psychosis" is characterized by a far higher rate of "heredity", both general and in particular also for the parents, need then not necessarily mean that these children differ significantly from the merely "infantile" ones by any hereditary factor, but only that their equally immature parents may have frustrated whatever chance they had of growing up harmoniously. In the group of infantile psychosis, 7 of the 17 children had remained behind the standards for their age in general physical development. In 4 of these children, (while in only 3 of the remaining 10) complications of pregnancy and delivery had occurred. In 5 out of these 7 children with infantile physical features, at least one of the parents suffered from some psychiatric disorder, while amongst the remaining 10 children "parental heredity" was only noted in 4. One may therefore assume that these "psychotic" children with infantile physical features may originally have been of similar constitution as the ones in the "infantile" group, but that the faulty attitudes of parents with functional disorders may have hampered and distorted their development.

One may then ask, why the parents of infantile children had come for consultation and why not all of them were found to be "accepting". We shall see later that with one exception, all "infantile" children were brought at ages between 5 and 7, very obviously at the time at which they were expected to start school ! This may have been the time at which the initial tolerance found its limits. On the other hand, as two of the examples will show, the wish to gain more understanding and more adequate means of dealing with a retarded child can be a reason for psychiatric consultation in the very parents who are not impatient to see a magic change.

Again, one has to assume that the children whom we saw, are only a small selection of all those that present similar symptoms. Parents without educational ambitions for their children, who let them grow up "just naturally", are probably not to be found amongst those who consult a psychiatric clinic.

As we have already digressed into general considerations, this may be the place for some remarks on the concept of "maturity", which nowadays, particularly in the context of "emotional maturity", seems to have become a rather overworked slogan. First of all, one should perhaps rather talk of "maturation", as a continuing process that to use the term "maturity", which suggests a result, a final stage at which one can settle down. "Maturity" is always relative, compared to age, or in terms of readiness for the tasks before one or, finally, measured against the potentials which, at best, one could have developed. A "state of maturity" which is regarded as a non-plus-ultra, the crowning glory of one's life, is nothing but stagnation. In a truly human existence, maturation continues all through life. Again, ancient Indian tradition with its life-

programme of the 4 ashramas, of which the later two foresee growth into still greater independence and spiritual depth even at an advanced age, betrays far more wisdom and insight into man's true nature than the modern ambition to provide for one's retirement, either by giving one's sons a good education or by joining a pension scheme and then to "enjoy one's leisure".

But, if "maturity" does not simply mean being able to hold successfully one's own at a level of respectable erudition, prosperity and public importance, what then should be the aim of human maturation? This may be a matter for philosophy or even for religious belief. One can probably safely say that "maturing" means to advance from a state which is all "taking" and no "giving", into a greater and greater capacity for giving with a minimum of taking. "Giving" and "taking" in this context have to be understood in the widest sense, not only concerning material transactions, but also such immaterial values as attention, concern, tolerance, protection, love, in short all that really provides a place in the world for a human being. Thus, as we already hinted in a former chapter, a mother who, according to all outward standards is "giving" amply to her child what he needs on the material level, still may, in her lack of emotional maturity, quite subtly be "taking" from her child in terms of fulfilment for her emotional needs, of protection in her anxiety, of confirmation of her own existence; and the child, on the other hand, instead of being able to nourish himself on pure "taking", is prematurely exploited by having to "provide" security and satisfaction of pride and ambition for his parents. It is against such invisible demands, excessive either absolutely or relatively to his retarded development, that a child may have to close himself up in autistic withdrawal. Closing up, stopping the traffic of give-and-take, however, renders any future maturing impossible. On the other hand, the ability to give, which ought to be a sign of maturing, can be stifled and atrophy, if the child grows up in an atmosphere in which he is never called upon to give or perhaps does not even have a chance to ask, as all his needs are automatically fulfilled. In reality, the situation is hardly, ever so simple that one could quite decidedly point out a lack on one side only; exploitation in one sphere can be very subtly covered up by an overshadowing with "giving" in some other respects. In a patient's attitude, one can often find clues that indicate, whether he has had to close himself up against being exploited or rather against being overpowered by an ill-placed "generosity", or whether he has had to defend himself on both fronts.

(b) *Causes and Origin.*

In the preceding paragraph on definition and differential diagnosis, we were already drawn into considering the problem of cause and origin of what we call "psychophysical infantilism".

One factor that frequently contributes to a general retardation, is premature delivery. The delicate and unprotected nervous system, probably also other physical functions, are exposed to stimuli for which they are not ready yet, while on the other

hand, the continuity of automatic covering of all needs, typical for intrauterine life, is no longer granted. Being thrown out of their natural rhythm and sequence, further maturation and growth are slowed up or remain stunted.

Incomplete or faulty formation of any particular organ-system, especially of the heart, the digestive organs, hormonal glands and probably also certain metabolic functions, can equally keep back general development. Genetic deterioration can be responsible for certain forms of infantilism, when the parents suffer from syphilis or when they are addicted to alcohol. In some cases, a severe illness in early infancy, particularly if it is associated with a dystrophic state, can slow up further growth. In these cases, however, one may wonder, whether a certain weakness of constitution may not already have opened the door to the disease.

Environmental factors seem to play a role insofar, as a child will only be recognized as "infantile", if there is someone who will apply a measure against which the retardation appears as abnormal. Parents with certain educational ambitions and cultural standards are more likely to show concern about an infantile child than a family in which children are allowed just to grow up naturally and in which possibly no one even keeps count of age, or where a mother may even find, in the retarded child, a convenient complement for her own anxious clinging.

Not only the parents' expectations can turn a child's slow development into a problem. Often the child himself becomes conscious of his being different, when a younger sibling catches up with or even overtakes his physical, intellectual and emotional growth. Even if the parents are reasonable enough not to urge the child on to "keep up his position", the siblings are very likely to establish comparison and to tease the one who remains behind. If a brother or sister, whom the retarded child has been used to consider as smaller and younger, suddenly defeats him in a fight, or if younger siblings are sent to school before he has become ready for this venture, this can seriously upset the equilibrium and cause dilemma, where previously the slowing up was still marked by a certain harmonious wholeness. If, amongst the children in our group of "infantilism" there are none older than 7, this may be, because, after that age, the strain of being measured against the level they ought to have attained in school, may have superimposed neurotic features that obliterated the original picture of a universal retardation.

One will see that most of the possible causes mentioned, are to be found in the children of our group.

(c) *Combinations.*

Two cases of the oligophrenic group were regarded as presenting also infantile features. In both, the intellectual development seemed to be inhibited to a degree slightly below the level of the obviously present general retardation. This

classification as a combination of oligophrenia with infantilism may be somewhat doubtful. Possibly the uneven slowing up may simply have been a reaction to the parental attitude, which was careless and neglectful in one case, openly rejecting in the other. Furthermore, malformation of the heart, which seemed to be present in both cases, may have affected the brain more than other parts of the body, through a particular distribution of the oxygenated blood. Both children presented other dysplastic signs too. The one boy, whose history will be given in the chapter on delinquency, was an unwanted child. It seemed highly probable that his intrauterine development had been disturbed through attempts at abortion, which the mother had undertaken during pregnancy.

In the neurotic group, we had noted infantile features in 8 of the children. In 5 of these cases, either pregnancy or delivery had been disturbed, while the remaining 3 showed discrete signs of organic brain-damage of undefined origin. As already mentioned, some of these children seemed to have neurotic symptoms superimposed on an originally uniformly retarded development, while others may have kept up or gone back to infantile features that fitted into their neurotic defence. Whatever the combination may have been, it looks, as if some very early disturbance in development, either of the whole organism or the central nervous system in particular, had facilitated the persistence of or regression to immature patterns of behaviour.

(d) *Characteristics of our Material*

As the group of "psychophysical infantilism" is so small, detailed tables and graphs giving the percentual distribution of various factors and features could hardly have any validity. Furthermore, as one will see from the synoptic table, (Table XVIIIa) only few of the characteristics analysed for the other groups seem to have any special significance. Instead of proceeding through the various paragraphs in detail, as we have done it for the bigger groups, we shall therefore only pick out the few aspects that seem to be relevant, illustrating them with summaries of all 6 case-histories.

The number of children is divided up equally between boys and girls.

As to age, we have already drawn attention to the fact that 5 of the children were brought for consultation at ages between 5 and 7, and of these again the majority between 5 and 6.

The one boy who was already examined by us at the age of 2, illustrates in an almost grotesque manner, what we tried to explain about the necessity that someone has to hold up a measure for comparison, if a child is to be labelled as "below the mark".

(103) This little boy, *Imtiaz*, was the only surviving child of a Muslim servant. Of the two elder siblings, a brother had died at the age of one month, a sister at the age of 2 years of a dystrophic state. The boy himself, at the age of about 1 year,

went through a severe febrile illness, which left him weak and dystrophic for a long time. The parents, though concerned about his physical health, were not particularly worried about the fact that, after this illness, his whole development was retarded and that he had not learned to speak yet, at the age of 2. It was the foreign "Memsahab", in whose house the father was a bearer, who was alarmed by the child's state. She had no children of her own and apparently was out to get some emotional satisfaction for her maternal instincts by seeing this child of her servant developing according to her notions. As, in the West, most children dispose of quite a good vocabulary at the age of 2, she assumed that something was seriously wrong with the boy, when he did not respond to her efforts to make him talk. She communicated her anxious preoccupation to the ignorant parents, who were even induced by it to subject the child to an operation against being "tonguetied". It was on her instigation too that the child was shown to us.

In view of the poor constitutional endowment, which had not even allowed the elder siblings to survive, the severe illness and the rather primitive environment, the child's general "retardation" did not present anything very extraordinary. If he had grown up in a village or in a labourer's mohalla, no one would probably have considered him as abnormal. Measured against the incongruous expectations of the foreign lady, his backwardness assumed problematic proportions. The case hardly deserves the designation "infantile" ; at best perhaps that of a "regressive state after severe dystrophic illness". As, however, we had to fix the diagnostic label to the child and not to the somewhat unrealistic "Memsahab", the group of "psychophysical infantilism" seemed most apt to give him a place.

Somewhat similar considerations, though to a much lesser degree, might be valid for some of the other cases, in which the parents' impatience seemed to weigh more heavily than the child's actual retardation.

In this one boy, the retardation had only been noted after the illness at the age of one ; but possibly he had not been within the range of the foreign lady's interest before that time ! All other children in the group had been observed to develop slowly right from the start.

Except perhaps for the inadequate development of speech, which was mentioned in most cases, and which was taken as a sign of lacking intelligence by some parents, the reason for consultation was not in first line an intellectual deficiency, but rather the generally childish behaviour. In 3 of the children, a certain amount of anxiety, *i.e.* a subjective symptom, was indicated.

As to local origin, the one child who is listed in Table III as coming from a village, was by no means a true village child, but came from a well-to-do, educated family on a tea-plantation in the Eastern regions of India.

The one child from a family with low social status was, as we have demonstrated above, brought for consultation on the initiative of the foreign employer of his father. Of the other fathers, 3 were in Government service, one a manager of a tea-plantation, one a lawyer.

50 per cent of the children came from Muslim families. Considering the small number of patients and the fact that one of these 3 Muslim children (Imtiaz, 103) had not really caused any concern to his parents, but to a foreigner, this figure might be considered as due to mere chance. Taken together with the relatively high percentage of Muslims in the neurotic group and their complete absence in the group of infantile psychosis, it may have some significance. The question would again be, whether the figures can be taken to refer to a greater frequency of incidence of such cases in Muslim families or merely to a different level of expectations in the parents. Or could it again be that, corresponding to the distribution of psychotic and almost-psychotic-but-still-neurotic adolescents between Hindus and Muslims, we have to look for the Hindu children more in the group of infantile psychosis, which indeed contains no Muslims? The fact that both infantile Hindu children present slight autistic features, while amongst the 3 Muslim children such tendencies only occur in one, might point in this direction. The figures, are, however, too small to draw any definite conclusion.

The fact that a child's retarded development is only experienced as abnormal when measured against a certain cultural and educational standard, may also be borne out by the observation that, of the two Hindu children, one belongs to a Brahman, the other one to a Kshatriya family. Furthermore, the mothers of the 2 Hindu children and the one Christian boy were fairly educated and emancipated.

Only one of the 6 children was known to come from a joint family. All children had both parents living.

Psychiatric morbidity, which at the same time was "parental heredity", had only been signalled in one family, that of the girl who perhaps came closest to being regarded as psychotic :

- (104) *Padmini* was a Brahmin girl of 5. Her father, a police officer, had been treated for syphilis before his marriage. A first daughter was born, when the mother was aged 18. During her pregnancy with *Padmini*, the second girl, she attempted abortion, but did not succeed. When soon after the birth of this child, she became pregnant again, she succeeded in provoking an abortion. At that time, she seems to have gone into an abnormal state that may have been hysterical, but possibly could have been of psychotic nature. Educated up to High School, she was perfectionistic and compulsive. One boy, born 3 years later than *Padmini*, had had convulsions in fever. He was, however, in many respects better developed than his sister and, at the age of 2, could talk more than she did at 5. At the time when we examined the girl, the mother was again pregnant.

The history given up to now indicates that the child may have been genetically poorly endowed by a father who had had syphilis and a mother with psychotic tendencies, that furthermore, as she was an unwanted child, her embryonal life had been disturbed by attempts at abortion and that, during her infancy, the mother probably had to neglect her during her phase of mental illness. It is probably no mere chance that all 3 girls in this group are second daughters, 2 of them followed by sons !

Padmini remained delicate and developed slowly. She started walking at the age of 18 months and only showed interest in talking at 4. Even when aged a few months above 5, she could not form full sentences yet. At the age of 3, she had sustained a slight head injury, when falling from a height of about 2 feet.

The parents got concerned about the delay in her learning to talk, when the younger brother had caught up with her in this respect. At the same time, they resented her stubbornness and disobedience. She had fits of anger, when anything went against her wishes. At times she would walk out of the house, pick up some food from a stall or shop and eat it. The family tried to make possession by a spirit responsible for her strange behaviour.

On physical examination, we found irregular heart-beats that might have been the sign of some malformation. The child was small, delicate and graceful. In striking contrast to this refined appearance, we noted rough, dirty feet covered with sores and scabs, an obvious sign that even her physical needs were neglected by the mother. Her face presented a strange mixture of sweet, childish innocence and a rather old, drawn expression round the mouth. During physical examination, she seemed to enjoy any procedure that involved gentle touch. She did not only eagerly take the chance of settling down in the doctor's lap, but also felt intense pleasure in fondling and clutching to herself a doll she found in the playroom. She made this doll "go to the latrine" and put her to sleep like a little mother. In some performance tests, she showed quite good motor co-ordination, but no understanding for any organized activity.

Whereas her lack of attachment to the parents, her reluctance to develop and use speech, her fits of stubbornness and her lonely roaming about suggested marked autistic features, her eagerness for human contact and her behaviour with the doll seemed to show that this attitude of schizoid withdrawal was not fixed, but could be assumed or discarded at will according to the surrounding circumstances. As the physical development was retarded in almost the same measure as the intellectual and emotional functions, and as the physical findings were suspect for some malformation of the circulatory system, it was felt that more justice could be done to the case by placing it in the group of infantile children and not into that of infantile psychosis.

Sibling mortality only played a role in the family of the little Muslim boy (Imtiaz, 103) already quoted.

This lack of hereditary factors seems to distinguish our small group of merely "infantile" children significantly from that which we have assembled under the heading "infantile psychosis". In the latter group, the percentages for general psychiatric morbidity amongst relatives, "parental heredity" and sibling mortality are all higher than the average for the total group of children.

The number of children born and surviving in the families of "infantile" children is smallest amongst all groups. Only one family had more than 3 children. In 2 cases, the parents used contraceptives to prevent the birth of further children. The other families had probably not reached their definite size yet, and further additions were to be expected.

In these very small families, nearly every child has a chance of being either eldest, youngest (at least for the time being !) or unique in some other way. The number of "special positions" is therefore very high. Even the considerable rate of 66.6 per cent of children who are eldest, youngest or only surviving, remains 20 per cent behind this figure. On the other hand, we have seen that one place prominent in this group, with 50 per cent of all cases and 100 per cent of all girls, is that of the second daughter, which we have not included in our series of "special positions". The history of the one boy who was the only surviving one, Imtiaz (103), has already been given. Both other boys were first born.

Only Padmini's (104) mother was aged below 20 at the birth of this second child. The mother of Imtiaz (103), belonging to the servants' class, may have been younger than 20 ; but we have no certain information. All other mothers gave birth to the children who became our patients at an age between 20 and 30.

While a disturbed pregnancy (in the case of Padmini (104), through attempted abortion) was only reported in one case, delivery was complicated in 3 cases : about one of the girls we merely know that delivery was "difficult" and that she had a "swelling" on her forehead for some time ; one boy, after prolonged labour and breech delivery, was "blue", *i.e.* asphyctic, and presented multiple swellings and bruises. Another boy was born prematurely during the 8th month. In both these boys we found discrete signs of brain-damage.

Whereas, thus, 4 out of the children in the infantile group, *i.e.* 66.6 per cent, sustained some damage either during pregnancy or delivery, this rate for the group of infantile psychosis only amounts to 18.7 per cent. We have drawn attention earlier to the stunting effect on growth which premature delivery or any damage to organs that are just on the point of development, can have. As an example, we present the history of the boy who was born prematurely :

- (105) *Neeraj* was the first child of a Christian Government servant. While the father at times tended to be a bit impatient, the mother was a shining example of real concern and understanding for this handicapped child. Both parents showed their accepting attitude by an eagerness for any advice we were able to give them.

During the 8th month of pregnancy, the mother suffered from dysentery. The child was born about 5 weeks before term and showed signs of immaturity. The mother was only able to breastfeed him for 1 month. The child remained weak and could not digest properly. At the age of 2, he suffered from pneumonia, at 4 from diphtheria. At the age of about 5, one year before we saw him, he had to be treated for tapeworm.

While his development was generally retarded, the motor functions in particular seemed to lack coordination. He only learned to walk at 4, and even at 6 could not keep his balance perfectly, so that he often fell. Up to the age of 4, he had been bedwetting. His speech, on the other hand, was fairly well developed at the age of 6. The parents had noted that he was easily scared, shocked by any loud noise. Probably exposed to too many stimuli, against which his immature nervous system had not learned to insulate itself, he was restless and unable to concentrate.

A somewhat deformed head, a high palate and a slight squint seemed to indicate that already intrauterine development may have been disturbed. The heart sounds too were not quite pure, making one suspect some congenital malformation. On neurological examination, we found a deficient control over muscle tonus and movements, particularly on the left. From both footsoles, pathological reflexes were obtained. When walking, the boy kept his legs wide apart, so as to gain a broader, safer base, and while running, he "ruddered" with his arms in an awkward manner.

The child impressed one as being 2-3 years younger than his chronological age. He was on one hand anxiously clinging to his mother, while, on the other hand, he showed a certain inquisitive interest in his surroundings. He could easily recognize objects in picture-books, but was quite helpless with toys that involved any motor function. The mother had started teaching him a few things at home.

The fact that the little brother, born 2 years later, was catching up with *Neeraj's* development, did not seem to make any difference to the parents' patient concern for the child. It looked, as if this boy might really have a chance of growing up according to his own reduced speed. The tranquilizers which we prescribed in small doses for reducing his excessive sensitivity, the roborants and the suggestions for massage and rhythmical exercises, seemed to give some encouraging results.

Unfortunately, data about the period of breastfeeding are very incomplete for this small group. Of the only two children whose mothers gave us the relevant information, one had not been breastfed at all, while the other one, Neeraj (105) just quoted, only received his mother's milk for one month. There is no evidence that any of the other children were breastfed over an extraordinarily long period.

Only 2 of the children, aged 5 (and of course the little boy aged 2 !) had not learned to control their excretory functions yet. Their incontinence was not the main reason for consultation.

Early neglect may have played a role in the case of Padmini (104) who was an unwanted child and whose mother went through a probably psychotic phase a few months after her birth. One other little girl, who certainly was neglected to a certain extent in later years, may already have been exposed to insufficient maternal care in early infancy :

- (106) *Asia*, daughter of a Muslim railway employee, was born 5 years after her elder sister. At the beginning of her marriage, the mother had had an abortion. Since then, she had always remained weak and sick. She seemed to have no understanding for her delicate little daughter and disciplined her so harshly, that the child lived in constant fear of her. The father seemed to be rather inconsistent in his attitude : at times pampering the child, then again scaring her by fits of temper.

After a complicated delivery, the mother could give no milk. The child was bottle-fed. The fact that, at the age of 6, she was far more attached to servants than to her own parents, may indicate that, right from the start, this second daughter did not get much direct attention from her mother.

At the age of 10 months, she developed some blisters in her mouth, possibly a sign of lack of vitamins. Later, she suffered from measles and pneumonia. She learned to walk at 2 and to talk only at 5.

When she was brought to us at the age of 6, her parents were worried about her imperfect speech, her mischievous behaviour, her fits of anger, in which she would beat and throw about things, and her habit of startling up from sleep with loud screaming.

Again we found a small, delicate child, whose general development suggested an age far younger than 6. Apart from a slight squint and an asymmetric bulge on the forehead, physical examination revealed nothing extraordinary. The child's nails were bitten, indicating repressed tension. She was overactive and fidgety and had no persistence in play. Some of her vocabulary was quite clear. Apart from these few conventional words, however, she used her "private language" of signs or "made-up" words.

One may wonder, whether the autistic behaviour of this child, particularly her use of "private language", should not rather characterize her as one of the psychotic children. What decided us to keep her in the "infantile" group was again the general retardation of development and the quite voluntary attempts she made at establishing an affectionate contact with the doctor. It may, however, be a significant pointer to the mother's negative attitude, that Asia only favoured the male doctor by her caresses, while she seemed to resent the approach of any female staff-member !

The four cases quoted up to now, have already demonstrated a variety of parental attitudes : normal and beneficial acceptance in the case of Neeraj (105) and, as far as this was within their primitive limits, by the parents of Imtiaz (103) ; careless neglect on the part of both parents in Padmini (104) ; contrast between an irritable, inconsistent and probably rejecting mother and an at least temporarily pampering father in Asia (106). The two remaining children illustrate still different attitudes :

- (107) *Salma* again is the second daughter of a Muslim family. $1\frac{1}{2}$ years after her, a brother was born, followed by another boy and a girl, so that finally she was the second of 5 children.

The father, a lawyer, was a short-tempered, strict disciplinarian with high ambitions for his children. The mother was similarly described : short-tempered and expecting a lot of her children.

The girl was brought for consultation at the age of $5\frac{1}{2}$, because she was "less developed than her brother at 4". She had not learned to speak clearly, and at times she wetted her bed. Her behaviour was often stubborn, and she did not seem to be able to concentrate.

Neither the history of pregnancy, delivery and early infancy, nor the physical examination, revealed any specific cause for a retarded development. The girl certainly was small and delicate for her age ; but unless she had been succeeded by more robust siblings and unless the parents had entertained some ambitious ideal notions of what their children should be, she certainly could have passed as still being within the range of fairly normal variations. Again, as in Imtiaz' case (103), a diagnosis had to be found for the child, and not for the overdemanding parents, and therefore "infantilism" seemed to correspond most accurately to the slight general retardation.

The impatient and perfectionist expectations of a rather irritable father were counteracted by the overindulgence of the mother in the last case :

- (108) *Sanjay* was the first-born child of a love-marriage between a manager of tea-gardens and a quite emancipated graduate, both Kshatriya. The two families first

opposed the union, but finally agreed. The parents were modern, not only in concluding their marriage, but they also planned their progeny carefully. 1½ years after Sanjay, a daughter was born. These 2 children were all they ever intended to have.

During a prolonged breech delivery, the child sustained various injuries and showed signs of asphyxia. 3 days after birth, he showed signs of jaundice. His teeth appeared at the normal time, but were small and deformed. He started walking at 1½, talking at 4. When we examined the boy at 5, his speech was not very well articulated and at times slightly stammering. At the age of 8—10 months, he fell from a staircase and probably was unconscious for some time.

Apart from the general retardation in his development, the mother had noted a certain irritability and excessive sensitivity. He was easily scared by loud sounds and by gatherings of people. He was shy with strangers, but showed no sense of danger in other respects. When disturbed in his play, he got easily angry and even beat his parents. At 5, he had not acquired perfect control over his excretory functions yet. He was very much attached to his mother and hardly wanted to leave her.

On examination, we found a slight deformation of legs and feet, imperfectly shaped teeth and discrete signs of brain damage. His movements were uncoordinated and his muscular strength poor.

As the boy had been brought up on a lonely plantation, where he seldom met other children, he had been spared any unfavourable comparison and teasing. Also, he had had the benefit of quiet surroundings. When he came for the visit to the city, during which the mother brought him to our Center, he was scared of the noise and rush and seemed to get more nervous.

While the father was rather impatient and moody, resenting that the boy did not come up to his ambitions and his perfectionist ideas, the mother showed a lot of understanding for his needs. If anything, she may have been pampering him rather too much. In watching his behaviour in the consulting-room, where he tried to investigate everything, including the type-writer, one got the impression that he had been allowed too much to fiddle with things that were not meant for children.

As the mother, while down in the plains from her lonely hill-home, wanted to take the chance for as thorough an investigation as possible, we referred the child to the District Psychological Center for testing. The report mentioned a mental age of 3-4 years. Verbal ability was best developed, while reasoning and memory functions were poor. He performed better in any test in which

objects were related to human figures and situations than when isolated shapes or lines were involved. From his lack of internal control over his restlessness and aggression, he had learned to protect himself, on one hand through clinging to his mother and expecting all guidance from her ; on the other hand he seemed to be able to release some tension through watching fast movement in objects, e.g. vehicles.

During one of the interviews with the mother, we had to help her to make a decision which probably was to affect the boy's development significantly :

The following year, both parents were supposed to go abroad for some time. In view of the boy's attachment to the mother and his helplessness without her, the obvious solution would have been to take the boy with her on this journey. But since the mother had seen, how scared and nervous the boy got on his visit to the Indian city, she had begun to doubt, whether it would be wise to take him out of his calm surroundings in the hills. Both factors certainly had their weight. It looked, however, at least at that time, as if the mother's protection were so essential to him, that even restless and new surroundings in her presence were less likely to harm him than the usual surroundings without her. We do not know, how the boy developed during the following year and how the journey was finally organized.

The presence of physical defects in 50 per cent of the children, places this group close to the average of 51.7 per cent amongst all children with functional disturbances. In 2 children, we suspected a malformation of the heart ; 2 had signs of organic brain-damage, and one of these 2, in addition, general dysplastic features.

The few children in this group seem to have been remarkably free from infectious illness : Only 2 were known to have gone through pneumonia, and 3 had suffered from various fevers. Accidental injuries were reported in 3. Possibly, as these children are all of a low age, they may already have profited by the area of better prophylaxis in recent years. Also, as most of them came from educated and fairly well-to-do families, they may have enjoyed better care and protection than some of the children in other groups.

None of the children had started school yet. The two older boys had been taught a little by their mothers. The fact that all children had approached the age at which they would normally have been sent to school, had certainly contributed to make their parents seek advice.

Special interests were only reported in 2 children. Both liked to play with water and mud. One enjoyed dealing with pets, while the other one preferred toys.

As in most of the cases all we could do, was to give the parents some explanations about the nature of the child's retardation and to advise them to have patience and

possibly to attend to some physical handicap, *e.g.* by further investigation of a possible heart defect, massage and exercises for weak and unsteady limbs, one need not wonder that only 3 children came back after a first visit. In the one boy whose parents came 4 times, a certain improvement of motility and emotional control was registered as a consequence of the treatment advised, already within 3 weeks. In all other cases, we had no information about any result of our therapeutic suggestions.

While it is relatively easy to grant to a child of pre-school age the right of still behaving like a baby, making such concessions becomes more and more difficult, when the child grows physically to a size and reaches a number of years at which one automatically expects more. It is then that the difficulties start and that neurotic defences may have to be superimposed. This may be one of the reasons why in our material there are no children older than 7 who were diagnosed as infantile. There is, however, one further reflection to be made: the fact that all of these 6 children were examined during the latter part of the observation period, between December 1958 and December 1961, makes one wonder, whether possibly parents are gradually assuming a less tolerant attitude with regard to their children's shortcomings, under the influence of the high value that is nowadays set on early intellectual training. The fact that, in the group to be discussed next, that of "infantile psychosis", an even more drastic concentration of the majority of cases into the most recent period is to be observed, and that Delhi Child Guidance Clinic too signals an increase in psychotic children during the last 2-3 years, certainly seems to indicate that the atmosphere in which small children grow up in certain types of families here in India, is undergoing rapid change.

8. *Infantile Psychosis.*

(a) *Definition, Differential Diagnosis.*

This group of 16 Indian children, to whom we can add the one Nepali boy as belonging to a culturally similar setting, presents one of the most interesting, but also one of the most problematic phenomena in our material. One will see that, with regard to symptomatology, this group is fairly well characterized and that no case presents less than 4 of the essential features. On the other hand, however, we find considerable variations in possible aetiological factors: from presence of a neurologically demonstrable brain-damage to the absence of any factor that would suggest a constitutional weakness; from seemingly "average" family atmosphere to an accumulation of severely unsettling environmental factors. Considering all these differences, great care had to be taken in choosing a name for this group which, even according to the opinion of psychiatrists with strict views on the subject, would cover all cases and yet retain the essential elements that distinguish them from those of other groups, *e.g.* that of mental deficiency, postencephalitic states, neurosis and infantilism.

The term "infantile psychosis", which we have chosen, indicates that the disorders assembled in this group concern children of a young age, as opposed to what we called

"adolescent psychosis", and that, in their quality, intensity and duration, they go beyond disturbances of behaviour which one could still classify as "neurotic" or as a mere "development crisis". We have tried to define earlier that the essential difference between a neurotic defence and psychotic withdrawal or disintegration may lie in the patient's attitude towards an "outside" or "common" world. While the symptoms of a neurotic still have the purpose of keeping up contact with this "outside world", though it may be a heavily "padded" or "strictly filtered" communication, the psychotic seems to be out to ignore or deny anything that could exist outside himself and as an agent separate from himself. This means that any defences would have the purpose of hermetically sealing himself against influences from this "outside world" or that the denial may be achieved through an indiscriminate symbiotic merging of the "I" with what a normal person would experience as "not I". While both these forms of defence, from the point of view of making the "self" the only subject (self in Greek is "autos") would deserve the name "autism", some authors, particularly with regard to disturbances in infancy and childhood, reserve it for the first alternative, that of withdrawal, while they designate the second one, the indiscriminate merging, as the symbiotic form of childhood psychosis. One will see that, in the cases in our group, withdrawal is in the foreground in a few cases, while a symbiotic clinging is more typical in the majority of children. One can, however, note that, in one and the same case, either tendency may prevail according to the atmosphere in which the child finds himself. In general, our observations seem to suggest that the symbiotic, empathic merging, which is a normal feature of embryonal and early infantile life, is kept up in any situation and with regard to any person that promises satisfaction of a need, while withdrawal is used as a defence against demands and "influences" that threaten to overwhelm the weakly developed ego-boundaries. One may even observe elements of both tendencies in one and the same situation or gesture. A child may frantically cling to someone, e.g. the mother, as far as physical contact is concerned, while, emotionally, his attitude betrays withdrawal, turning away from any communication through visual recognition, loving gestures and, above all, the link of speech.

As "autistic features" of this kind can be noted in all the children in our group, one may wonder, why the term "infantile autism" has not been used to designate it. In a wider sense, this would certainly characterize the group very comprehensively. The term "early infantile autism" has, however, been coined by Leo Kanner to cover a quite well-defined group. According to a recent paper by Bassa (29), Kanner's concept can be summed up as follows: "Early infantile autism is the earliest manifestation of childhood schizophrenia, characterized by withdrawal, obsessive desire for preservation of sameness, skilful and affectionate relation to objects, the retention of intelligent and pensive physiognomy, and mutism or language which does not seem intended for the purpose of interpersonal communication and which is marked by irrelevant utterances and reversal of pronouns. The cases he described were free from any organic defects, including that of the central nervous system."

This definition would not cover all the conditions assembled in our group, as many of the children presented signs of organic brain-damage or other criteria that

made one suspect a constitutional physical insufficiency. Furthermore, as none of our little patients were seen before the age of 4, and as information about early infancy was often vague or meagre, the presence of the first symptoms in earliest infancy is not always conclusively proved.

Other authors again *e.g.* L. Bender, quoted in the same article by Bassa (29), regard infantile autism, which they apparently consider as equivalent with childhood schizophrenia, as a form of encephalopathy, attaching very little importance to environmental factors. Still other authors would like to know the term "childhood schizophrenia" carefully distinguished from any psychotic manifestation that might be based on organic damage.

A combination of constitutional factors involving the function of the nervous system and of environmental influences is assumed by other observers, *e.g.* B. Fish (30). According to a summary of this paper (19) in *Excerpta Medica* (1960, p. 1048): "There does not appear to be a fixed neurological defect, but rather a disorder of timing and integration of neurological maturity. Whether or not the early neurological disturbance is followed by clinical schizophrenia would depend on the severity of the intrinsic disturbance and the effect of maternal and environmental care."

A similar point of view is maintained by A. Van Krevelen (31) in a paper which is summed up as follows (*Excerpta Medica*, 1958, p. 99.) (19): "In 1943, Leo Kanner in the USA described a syndrome which he designated as early or precocious infantile autism, characterized by the fact that from birth the patients tend to be isolated because of difficulty in making interhuman contacts. He considers this to be a consequence of the indifference and lack of affection of the parents. The author is of the opinion that autism is an aspect of a global organic disorder, although its pathology is unknown. Although the psychogenesis is admitted, it will undoubtedly have a secondary effect on the intelligence because of its early appearance. If the hypothesis of the central and organic character of autism, frequently of post-encephalitic character, is correct, prognosis is poor".

A combination of a physical or generally constitutional weakness or peculiarity, which can have the form of specific brain-damage, with psychogenic factors in early environment, is also what our material suggests. We therefore have chosen the wide term "psychosis", which, in contrast to "autism" and "schizophrenia" with their strict meanings, neither imposes any limits for the time of onset nor of the aetiological factors involved. It looks, as if again, we had to assume a sliding scale, ranging from the presence of neat neurological signs with relatively little harmful environmental influence, to the other extreme at which a seemingly healthy and fully developed baby is exposed to severe traumatic experiences in early infancy. It may, however, be remarkable that, whereas our scale contains one case in which any evidence of a constitutional bias was lacking, there is not a single child,—even amongst those who presented very obvious brain-damage,—who was not exposed to at least 3 environmental factors

that seemed significant in producing an emotional disorder. In contrast to all other groups, in which at least some of the children had enjoyed a moderate degree of acceptance by both parents, none of the psychotic children had the benefit of undivided parental concern and acceptance. In the two cases in which normal acceptance seemed to be the attitude of at least one of the parents, it was the father who showed this concern, while the mother was either neglectful or rejecting ! Further factors that seemed to be decisive, as one will see from the synoptic Tables (Tables 21, 22 and XVIII a), were "lack of parents" (including difficult marriage situations and studying or working mothers), position in the sibling, row, sibling rivalry, age of the mother at the child's birth and length of the period of breastfeeding.

As neurological disturbances similar to the ones found in almost half of the children in this group were also noted in other groups, they themselves can certainly not be the unique reason for the children's psychotic development. We find that the 4 children in the postencephalitic group, in whom isolated autistic features were noted after the infectious illness, as well as the 3 children in the "infantile" group who presented mild or sporadic autistic tendencies, all were exposed to unfavourable parental attitudes similar to those prevailing in the families of the psychotic children !

Another observation points to the essential role which the emotional climate of the environment plays in determining whether a weak or handicapped child will open and unfold himself to the best of his capacities, or whether he has to seek security in autistic withdrawal or symbiotic clinging : It is rather remarkable that 8 out of the 17 psychotic children were examined by the author during the last 6 months of her activity at the Psychiatric Center, *i.e.* between July and December 1961. Similarly, all 4 postencephalitic children and 2 of the 3 infantile children in whom we found autistic tendencies, were examined either in 1960 or 1961 ! One may of course reasonably object that child psychiatry is only just "coming into fashion" in India. But the fact that the frequency with which children were brought for consultation only fluctuated very little as a whole from year to year between April 1956 and December 1961, speaks against this argument. Psychotic behaviour in children represents one of the most serious disturbances and, if parents are at all inclined to make use of psychiatric facilities, one can safely assume that they would consult them in first line for severe disorders of this kind. As organic affections of the central nervous system, in particular postencephalitic states, and children who are quite generally retarded in their development, have presumably existed in all ages, one has to assume that the last few years, with their rapid social and cultural change, must, perhaps in some quite subtle way, have changed the environmental conditions that determined the growth of such children. Even if similar psychotic states already occurred in earlier periods, one must at least suppose that parental tolerance for them has changed in modern times ; but a lack of tolerance of this kind might at the same time indicate an attitude which in itself has already been responsible for shaping the distortion. Our observations in this respect seem to be confirmed by Delhi Child Guidance Clinic : Not only do the statistical figures for "schizophrenic trends" or "reactions" show a definite increase in recent

years (from 1.6 per cent in 1955-56 to 3.4 per cent in 1960-61, and from 13th place in the order of frequency of disorders to 7th rank !), but the Director B.D. Bhatia, specifically mentions in his Annual Report for 1960-61 (5) that "there is rise in number of cases showing schizophrenic reactions", and in a recent letter to the author (November 1962), based also on the as yet unpublished statistics for 1961-62, he comments : "I agree with you that there has been an increase of the psychotic phenomenon in children in India under the influence of the changing social structure."

Amongst the almost 500 schizophrenic patients above the age of 16 in our material, there are only 2 in whom we had reason to suspect a manifestly autistic development right from infancy. At the age of 19-20, both presented hebephrenic symptoms. Both had mothers who themselves behaved in very autistic manner and who were regarded 'crazy'. One as was an only daughter amongst 6 brothers ; the other one an eldest son.

One factor that might have played a role in increasing at least the number of children in whom a psychotic disorder could superimpose itself on congenital brain-damage or a general constitutional weakness, might be the reduction of infant mortality through the advances in medicine and hygiene during recent years. One might suppose that children with a feeble capacity for holding their own in this world, thanks to better health-care, may remain alive to lead an emotionally crippled existence, while formerly they would have died. If, however, we note that the figures for sibling mortality in the families of psychotic children are amongst the highest of all groups (43.7 per cent of all families and 19.0 per cent of all their children !), this objection rather loses its power of conviction !

If, in view of these figures and arguments, we have to accept that psychotic conditions in small children are on the increase here in India, one might ask, which are the factors responsible for this change. Is it, as we have already suggested, due to a specific "modern attitude in parents and in particular mothers ? Is it a consequence of the general social climate or even, if we once again resort to old Indian tradition one of the features typical for the spirit of the "Kal Yug" ?

Those authors who regard infantile autism entirely or predominantly as a psychogenic disorder, devote great attention to the mother's lack of interest and emotional warmth with regard to the child. The attitude of both parents is described as impersonal, as just registering the child's presence in a matter of fact manner, as unable to provide the true human care which can open up to the child a meaningful world and the security of being accepted and sheltered in "being together" with other human beings. Spontaneous warmth and ability for close human communication, can certainly suffer, wherever women turn away from their primary role as wives, mothers and homemakers, trying to gain emancipation through intellectual pursuits and work outside the home. Such active, deliberate discarding of a mother's essential task of being a link, of representing and providing relatedness, closeness, "being there for someone", actually

can be traced in some of the mothers of the psychotic children in our material. On the other hand, we find mothers who had not "gone with the time" at all and who, on the contrary, were helplessly left behind by the intellectual emancipation of more highly educated husbands. Further mothers were anxious and insecure in irregular marriage situations. Other parents again both seemed to be helpless and emotionally immature, themselves probably victims of the increasing need for emergence from collective patterns of living and of the isolation and emotional impoverishment associated with it.

Some American authors maintain that they have never found an autistic child whose mother was not sophisticated and who did not, in some way, merely consider the child as an object for scientific study and observation. Other authors again point out the ambivalence and inconsistency in the attitude of mothers of psychotic children or their need for protecting themselves against their own insecurity and loneliness by clinging to the child. Our material will also provide some illustrations for these latter attitudes.

Already this enumeration of possible ways in which parents, and in particular mothers, can deviate from a pattern of "normal" acceptance, has led us into showing parental attitudes which are not characterized by an active adoption of modern ideals of emancipation, but rather by the parents'-being swept passively along by a current which they themselves cannot resist. If "modern" trends are contributing to an increase of psychotic reactions in children, we therefore have to assume that they do not only act through a definite, wilful change in parental attitudes, but also more diffusely through the social transformation in general, which demands emergence from symbiotic-empathic forms of living. While the clear definition of individual limits may never have become a necessity within a close-knit joint family and quite generally in a social structure which encouraged such collective patterns, the present social order requires the individual to be aware of himself as a separate unit and a responsible agent. If parents have been precipitated too rapidly out of the secure old condition into this new social atmosphere, they may not have been able to constitute their own limits and can therefore not provide the firmness against which the child could form and define his own personality structure. Furthermore, children who constitutionally have little capacity to develop strong ego-boundaries, may have been sheltered and held together by the firm cohesion of a joint family. In a world which expects them to stand by and on themselves, they will be exposed in all their weakness, unless they find refuge in an autistic defence.

Beyond these personal and social factors, one might, if one is so inclined, incriminate the "Spirit of the Age" for revealing and throwing into the foreground a particular mode of human existence, which in other times may have been more charitably hidden and sheltered. One of the characteristics of the Kal Yuga which dominates our time, is supposed to be the spirit of ruthless exploitation and iron harshness. In its atmosphere, any tender, sensitive being will have a difficult stand and risks to be "impressed"

rather than to find a scope for expressing itself. Furthermore, the general obsession with valuing a thing or even a human being for its usefulness, which one can exploit, seems to have taken hold even of parents' attitudes with regard to their children. One may argue that, in old times too, an eldest son, for instance, had to devote his life to the family and a girl had to prepare herself for being "useful" to her husband and in-laws. For one thing, there was no other choice at that time ; it was the generally accepted pattern. Furthermore, however, such duties had their place within a religious order by which both, parents and children, were bound and held. If parents desired a son and rejoiced in one who had already been born, their longing and the satisfaction of it did not concern their own convenience, pride and ambition only, but they could see themselves as well as the child as links in a chain, as parts of a bigger whole that transcended both of them. This subordination to the command of "dharma", did not only provide a security within which the parents in their turn could shelter the children, but it also lifted the relationships beyond a mere commercial give-and-take, as, whatever was received or granted on either side, had its place in a higher order, to which both, parents and children, were committed. Nowadays, the establishment of firm individual limits often seems to shut out any transcendental values and, what formerly may have been stewardship in the service of a higher order, tends to become selfish exploitation. "Others" are no longer seen and respected as beings in their own right, with an equal status before a Divine power, as individual manifestations of the same supreme Self, but merely as objects to be used for one's convenience and advantage. One of the fathers seen by us, a Brahmin in a high academic position, seriously discussed with the doctor his view that human beings as useless and troublesome as his psychotic son, should be done away with !

Such ruthless use, however, and the risk of being "impressed upon", are the very dangers against which the autistic defence seems to be put up. On the other hand, rather paradoxically perhaps, the autistic person himself only recognizes the world as far as it can serve to satisfy his needs and wishes, as far as it happens to coincide with his own "private world". Thus he appears to be a protest against the spirit of exploitation of our time, while simultaneously he represents a sad caricature of it !

It seems, on the whole, as if one could roughly distinguish two extreme situations which can induce an autistic response in the child : either he lives in an emotional vacuum, in which no human contact really reaches him ; or he is engulfed by an atmosphere of overwhelming empathic emotions, which again cannot touch him, but only swallow him.

A lack of distinct, well defined existence is typical, not only for the embryo, but also for the very small infant. Contact with other human beings, the experience of the reliability of their care, but also of the independence with which their will can set up limits against one's wishes, gradually create a sense of individual identity and separateness or what one often calls "ego-boundaries". Even in the world of physics,

it is recognized that any contact between two bodies results in a loss of potential energy, which is transformed into "friction energy" and, under certain conditions, subtle processes of mutual influence and at the same time delimitation by the formation of some kind of "contact membrane". A similar process of formation and definition (the word "definition" from Latin "finis", end, border, actually means the same as delimitation !) seems to take place through human contact. Even in adult age, a person can, while alone, or even more in his dreams, imagine himself to be anyone and anything. When faced with a concrete partner, he has to limit his potentials and to "define" himself as a particular person who reacts in a "formal" way to a given situation. One can imagine that, if the adequate stimulus of such human contact with another subject is lacking, the child may not be able to develop and become aware of his boundaries. Situations in which this adequate stimulus can be lacking, are the following :

The child is neglected by an emotionally cold, possibly herself autistically withdrawn mother or brought up in machine-like, anonymous surroundings, as *e.g.* in a hospital or badly run children's home. The child is then likely to create limits for himself by withdrawal, by closing out the threatening vacuum and establishing his own little universe within. The child can be excessively pampered, so that he never has a chance of experiencing his limits by bearing frustration or resistance. At the same time, the parents' adoring attitude may get him used to the idea that this whole universe is set up entirely for his pleasure and command. He may go into expansive ideas of omnipotence, as long as this position is uncontested. At the same time, any resistance, which gradually he cannot avoid meeting, will provoke anxiety, against which he has to defend himself either by clinging to someone or by shutting himself off. This might for instance be the fate of a first-born child or son, who later sees his uniqueness threatened by the arrival of siblings ; or possibly even the rivalry by other children on entering school may constitute a threat. A third possibility is that the child lives in close proximity of a significant adult, in particular the mother, who herself has not achieved an individual limitation and who therefore clings to the child, in an attempt to confirm and define her own existence. The child may either allow himself to be swallowed up and then be unable to grow into a separate being, or, trying to defend himself, he may again have to withdraw. Finally, a child can be exposed to contradictory attitudes either between both parents or in the inconsistent behaviour of one of the parents. Not knowing, towards which side to direct his defence or at least to "define" himself, the child may have to close himself in completely.

Though all these possibilities may seem to differ considerably from each other they all have something in common : Parents with attitudes of the types described, do not recognize and accept the child as a being in its own right, with its own destiny of becoming a conscious and responsible agent, but merely perceive and experience,—or even ignore !—him in terms of their own emotional needs and conveniences. Again : the child on one hand has to defend himself against such attitudes, while, on the other hand, he actually uses them himself in possibly grossly exaggerated form. The result may look like "heredity" of a specific type !

The particular way in which discrete brain-damage or any general weakness of physical constitution can dispose a child to neurotic and psychotic reactions, has already been discussed in the chapter on neurosis. In a healthy baby, the body itself, as a well-defined structure, together with its various gross and subtle functions designed to deal with the "outside world", by keeping out what is harmful and by digesting and assimilating what is nourishing and sustaining, provides a kind of primitive distinction between "I" and "not I", which the child gradually discovers after being separated from the mother's body. Added to this, as a further help in finding his identity, are the functions of the various sense organs and the intellect as discriminating and dividing forces. Thus, a child endowed with all these functions intact, even in surroundings that for some reason do not favour the growth of firm ego-boundaries, still has some kind of serviceable contact-membrane. If, however, the child is born with deficient "insulation", conditions that would leave a normal constitution untouched and unshaken, risk to crush, to invade or to engulf him. The immaturity of the insulating nerve sheaths in premature or brain-damaged children in perhaps only a particularly obvious and illustrative example of such lack of ability to protect oneself from outside influences and to sort out and assimilate what one allows to touch or enter. Other defences or filters may well be represented on the physical level not only by the gross digestive processes, but by subtle metabolic reactions which manage to convert "foreign matter" into the body's own particular protein.

In the womb, the baby is nourished by juices which probably need hardly any transformation in order to become his own specific substance. Even breastfeeding still provides him with a nourishment that is practically "homeoplastic", *i.e.* consisting of compounds which can be used more or less as they are, without much work of breaking down, detoxicating and re-building into his own specific matter. The fact that in the only child in our psychotic group in whom no "organic" factors were found, sudden weaning seemed to be the main traumatic factor, may point to a basic inability of assimilating, which was brought out by this precipitated change from "homeoplastic" nourishment to "foreign matter".

Similarly, while a child lives in a family with a climate that corresponds to his own emotional "make-up", he can let influences pass without much control and without much effort at "making them his own". Gradually, however, not only the body ought to learn, how to deal with "foreign matter", but also emotionally, morally and socially, the child has to grow capable of resisting, transforming and assimilating influences from an "outside world", even if they go against the grain. What we call "vitality" "life-force", may perhaps consist in this ability to make "foreign matter" or the "outside world" one's own, to be able to accept or transform even that which is different or hostile to one, without being overwhelmed or poisoned by it. A lack of such vitality may possibly express itself physically in a more or less obvious disturbance of a particular organ system or more discretely in a weakness of certain metabolic processes. Possibly the frequent "liver trouble" in Indian children may be a psychosomatic manifestation of this kind, as the liver, above all, is the organ that detoxicates and transforms

what is "foreign" to the body. Observations about disturbed liver function in adult schizophrenics might point in the same direction. Again it may be worth remembering that, in Hindi, "kaleja" is not only used to name the liver as a physical organ, but also to designate such qualities as courage, initiative, ability to deal with a difficult situation! On the other hand, either as a secondary consequence of such physical disturbances or as a primary feature, this lack of vitality may also reveal itself as a quite general vulnerability and defencelessness of an existence that cannot define its limits.

Reflections of this kind would explain, why there are so many children in our psychotic group in whom certain factors point to some constitutional weakness. One may then have to wonder, whether the cases described in Western literature, *e.g.* those on which Kanner evolved his concept of "early infantile autism", as a deviation *not* based on any organic damage, were exposed to much more severely traumatic environmental influences than these Indian children, or whether, after all, a subtle expression of the inability to distinguish and to assimilate on the physical level may have been overlooked!

Ambivalence, together with autism one of the most typical attitudes in schizophrenia, might also find its explanation, if we assume, as a basis for such disturbances, an insufficient ability to limit oneself and to deal with "foreign matter". One of the great problems that seemed to vex many of our patients, adults, adolescents and even one of the children whom we had occasion to observe for a long time, was not only their simultaneous "love" and "hatred" for one and the same person, but quite generally the dilemma, whether a thing or a person that was "different" or one that was "equal" could be more acceptable or, on the contrary, more threatening. While against a "difference", one can set oneself off as separate, even if one's limits are not perfect, there is danger of being invaded by it; and as the powers for transformation are lacking, this may mean "poisoning". If, on the other hand, one is approached by something that is "equal", one need not fear invasion or poisoning, but one risks to obliterate the limits of one's personal identity, which means helpless merging or being swallowed up. The frequent fears, quite literally verbalized by such patients, of being "poisoned", "killed", "annihilated" by certain people or influences, may reflect this basic lack of powers for limitation and transformation. The solution lies in physical withdrawal, in building up an artificial wall of spite, negativism and stubbornness, a wall which is only designed to "keep out", but not to allow communication.

We have, however, no right to indulge in further theoretical speculations, tempting as they might be, without illustrating their validity by the actual case material which stimulated them. Further elaborations of the hypothetical reflections are therefore to be given in connection with the individual case-histories.

(b) *Causes and Origin.*

The preceding paragraph has already dealt with the various theories about the possible causes for psychotic reactions and developments in childhood. The synoptic

tables on the following pages (Tables 21 and 22), give a survey of the factors which seemed to be involved in the cases in our group. A first table, with more detailed data (Table 21) gives the cases in the order in which they came for consultation. The second table attempts to establish a kind of "sliding scale" between the extremes of cases in which organic and constitutional factors seemed more essential and, on the other side, those in which psychogenic environmental influences appeared to have been more powerful.

It is, of course, difficult to weigh such factors against each other and, all we could do, was to proceed on the strength of a quantitative evaluation of their number. In a first section, we have arranged all the cases in which neurological examination revealed signs of brain-damage ; in a second one those in which there was no evidence of brain-damage, at least not of a lesion localized in an area with motor or sensory consequences.

In the vertical axis, we have lined up first all factors that might have determined a physical or generally constitutional weakness, such as dysplastic signs, disturbances of pregnancy, complications of delivery, psychiatric morbidity or "heredity" in parents and in the rest of the family, sibling mortality, former illnesses of a type that might have caused a general weakness or specific damage to the nervous system. In a further column, we have registered the lefthanders, *i.e.* children who, after the age of 4, either had not made their choice of the dominant side yet, or who definitely were using the left hand for most performances. One will, however, have to realize that lefthandedness, though it can indicate an organic weakness of the right side, could possibly also be a sign of autism, refusal to conform to the pattern of the "common world". In many small children, one can note that, up to a certain age, they are "ambidexter", *i.e.* able to use both hands equally well ; what decides the final choice of the dominant side, is custom and not a biological preference ! So "lefthandedness" only has a limited value as an indication of possible organic brain-damage, while a continuation of the "ambidexter" stage beyond the usual age, may indicate a certain immaturity of the nervous system. In our tables, the cases marked with "x" indicate children who definitely were using the left hand more, while the marking "(x)" is used, when both hands were used equally.

Finally, we have tried to give some indications of the physical constitution. This column was added in order to illustrate the possible connection between a generally retarded, immature or "infantile" constitution and an autistic development. In the counting of factors, this column was however not included. One will see that, except for 3 cases, 2 of them rated as "average" and one as "sturdy", all children were either of infantile or delicate body-type or then dysplastic : one of asthenic type, the other one with features that came close to Froehlich's Dystrophia adiposogenitalis (a pituitary-diencephalic disturbance, characterized by fatty deposits of more feminine type and a deficient development of the genital organs).

A second section along this vertical axis contains the environmental factors that seemed to be relevant for the origin of the disturbance. Amongst them, one will

find ; lack of parents (including one working and 2 studying mothers and 3 polygamous marriages), position in the sibling row, young or old age of the mother, excessively long, particularly short or abruptly terminated period of breastfeeding and parental attitudes. As the latter showed some deviation from normal acceptance in all cases, this column was not included in the counting of factors. Where, however, either of the parents presented features of a more pathological kind, these are ranked as "parental heredity". The influence of emotionally unbalanced parents has thus been weighed in its double aspect : that of a possible hereditary transmission of an abnormal constitution and that of environmental influence.

In each of these 2 sections, we counted the number of features which presented anything extraordinary (either marked by "x", "xx" or "(x)" or then by under lining of the verbal rating) and which might have contributed to the child's abnormal development. The factors for either section were then correlated and a kind of index of "organic and constitutional involvement" calculated (*see* top column).

The question arose, in what sequence to arrange the cases, so as to get a proper "sliding scale", with the most organic-constitutional cases at one end and the purely functional ones at the other. If we merely had taken account of the size of the index, the cases which showed definite signs of organic brain-damage would have been scattered all through the row, as some cases without demonstrable neurological deviations were more heavily loaded with other organic-constitutional factors. We have therefore established the two separate divisions for cases with neurological symptoms (Table 22 A), and those without such signs (Table 22 B). According to the weight one attributes to actual signs of brain-damage (which were not included in the count of the "index" in part A of the Table), one can therefore read the whole horizontal line as one scale, assuming that such damage in itself, without regard to other factors, classifies the case as predominantly "organic", or one can read the 2 sections A and B separately. One will further note that it is not the absolute number of factors of either kind that decides the place of a case even within these two sections, but the ratio between the "organic" and "psychogenic" factors.

Below the columns already mentioned, we added a field for listing the various symptoms, hoping that perhaps this arrangement could give us some clue about the way in which the various factors might shape the psychosis. The number of symptoms observed does not seem to show any correlation with the number of causing factors. The last case in the row, for instance, in whom no organic and constitutional factors were found, and in which we only knew of two possible psychogenic factors apart from the harmful parental attitude, presented 9 of the listed symptoms, *i.e.* the maximum observed amongst all children. (In the Table, clinging and withdrawing, as either one or both of them are present in practically all cases, have not been included in this count. For this case, the count therefore is only 8 in the Table, while the figure 9, just given in the text, includes "clinging"). Some of the cases which are most heavily loaded with factors of both kinds, on the other hand, only manifested 4 to 5 symptoms. In a count

of this kind, we can of course not weigh the intensity or extreme quality of each symptom or factor ; nor can it do justice to the quite particular interplay between constitution and environment in the individual case. The table may, however, present a certain interest in view of the controversy which is still going on amongst psychiatrists with regard to the organic or psychogenic nature of infantile autism.

As we have pointed out earlier, there is no case in which environmental factors are lacking, while in at least one boy no evidence of organic or constitutional weakness was found.

One serious limitation of this table, as indeed of the whole material on which this chapter is based, lies in the fact that few children were seen for more than one consultation. It is quite likely that further observation of the children might have revealed more symptoms and that a continued relationship with the parents might have given further clues about environmental factors.

Further details about each column and illustrations by case-histories will be found under the separate headings of the following paragraphs.

(c) *Combinations*.—In one case, in which severe intrauterine brain-damage appeared to have reduced intelligence to the degree of imbecility, we observed symptoms that did not seem to be entirely the consequence of mental deficiency, but which suggested an autistic development. As the child at the same time was severely handicapped in his sensory functions, it is even possible that the "mental defect" itself may only have been an aspect of the autism, caused by this sensory isolation. As we only saw the child once, we had no chance for detailed observation, which might have given clues about the true nature of the defects. We therefore rated him as oligophrenic with superimposed autistic development :

- (109) *Jumna Prasad*, aged 4, was the son of a poor Shudra labourer. The parents, both of rather weak physical constitution, showed kind concern and understanding for the child within their primitive limits.

A first child, a girl, was developing normally. At the time when we examined the boy, the mother was expecting a third child. Our patient was born at term and without complications, after an uneventful pregnancy. Since birth, however, the parents had noted that he did not seem to hear and see. By the time he had reached the age of 4, he had learned to say "amma" and "baba". He would cry, when hungry, but could not announce his toilet needs. At times he would bite his own fingers.

He was lean, weak and sickly, looking much younger than his age. His limbs were loose and hyperextensible, so that he could not even sit up straight without

support. His eye movements were uncoordinated and he seemed to respond neither to visual nor to auditory stimuli. At the same time, he did not look idiotic, but betrayed a certain mental alertness. What gave one the impression that, in his sensory isolation, the child had developed according to the autistic pattern, was the way he seemed to be absolutely absorbed in himself, and the stereotype manner in which he clapped his hands, quite oblivious of his surroundings. At times he would bite his own fingers.

A stool test showed the presence of tape worm, *i.e.*, a parasite that may have presented a considerable drain on the already limited physical resources of the child.

This is the only case in which autistic withdrawal was so prominent that we regarded it as an actual "combination" of the basic diagnosis with infantile psychosis. In the 4 children of the postencephalitic group and the 3 of the group of "infantilism" in whom autistic features had been noted, they were not so striking that they could not have found a place within the main diagnosis.

That all these children were exposed to faulty parental attitudes similar to those in the group of "infantile psychosis" and that in all of the infantile children with slight autistic features pregnancy or delivery had been complicated, has already been mentioned.

Some psychiatrists might of course have preferred to have the cases in which autistic behaviour was combined with organic brain-damage discarded from the group of "infantile psychosis". Again, we have to say that the neurological symptoms were discrete and not known to the parents. Also, in contrast to the few cases with slight autistic features in the postencephalitic group, the first symptoms were not dated after an illness that could have produced cerebral complications, even where an infection of that kind had been signalled. As we have deliberately chosen the wide term "infantile psychosis", and not "autism" or "schizophrenia" to designate the group, we feel justified in including these "organic" cases. We leave it to the discretion of the reader, whether they are to be regarded as some form of "organic psychosis" or as genuine "functional disorders" based on or perhaps merely facilitated by slight brain-damage, or whether, in a total psychosomatic approach, the "organic" signs and the emotional syndrome are to be taken as different aspects of a same fundamental inadequacy of human existence.

(d) *Characteristics of our Material.*

(1) *Distribution according to sex.*—Amongst all functional groups, the psychotic children present the largest predominance of the male sex, with a ratio of 3 boys to 1 girl, or even 3.25 : 1, if we also include the Nepali boy. A similar ratio is only found amongst the oligophrenic children. Three of the 4 girls, all with infantile physical features, are amongst the 8 children with signs of brain-damage. In the one remaining

girl, the "constitutional" factors outweighed the psychogenic ones at a rate of 5 : 3. This makes one wonder, whether boys quite generally, and particularly in their position as eldest or only sons are more exposed to harmful environmental influences than girls. In literature we found one reference which stresses the higher incidence of infantile psychosis in boys, especially in first-born sons.

(2) *Distribution according to Age.*—Distribution according to age (Graph Ib) follows a pattern somewhat similar to that in the infantile group, but on a wider scale and with more scattering towards the older ages. The majority of the children were aged between 4 and 6 years, when they were brought for consultation. Even in the ones who were older, signs of abnormal behaviour had been observed since infancy or, in 3 cases, at least since the age of 3, which does not exclude that symptoms may have existed before, but that they escaped the parents' notice.

Only one boy could be followed over a longer period. He was first examined by the author's predecessor at the age of 7. By the time he had reached the age of 13, he had, with fluctuations and variations of symptomatology in the meantime, reached a state which approached a more adult schizophrenic psychosis, with predominantly hebephrenic and some paranoid features. His development seems to point in the same direction as that of the 2 adolescents in the adult group, who, at the age of 19-20, presented a predominantly hebephrenic symptomatology, after having gone through an autistic development since early childhood.

This paragraph on age may be the place to point once more to the remarkable fact that almost 50 per cent of the psychotic children were examined during the 6 months between July and December 1961, and only 17.6 per cent during the first half of the observation period of 5½ years. The possible implications of this uneven distribution have already been discussed.

(3) *Reasons for Consultation and Main Symptoms.*—Again the general Table (Table IV) of main symptoms can only give a very limited impression. It merely lists that practically all of the children were brought for behaviour disturbances, that a little less than 50 per cent presented impairment of intellectual functions and that some suffered from subjective symptoms such as anxiety. Autism to a psychotic degree was of course present in all cases as a matter of definition.

The synoptic Tables (Tables 21 and 22) give a much richer, more detailed picture of the various symptoms found in these children.

As we have shown earlier, the inability to communicate with the "outside world" and in particular with fellow human beings, may betray itself in withdrawal or in an anxious, childish clinging or possibly, according to circumstances, in both of these defences. The fact that in 3 of the cases we could not mark either of these columns definitely, is probably more due to lack of information and insufficient opportunity

for observation than to an actual absence of such tendencies. In all 3 children, other features, such as mutism, obstinate behaviour and temper tantrums indicated the autistic attitude sufficiently. While "withdrawal" from a really meaningful contact was of course a quite universal feature, we marked it particularly in those cases in which we could observe such behaviour during consultation. The column for "clinging" too was mainly marked on the basis of our own observation. What we could ourselves note, however, depended not only on the unfamiliar situation as such, but also on the persons who were accompanying the child. In Table 22, we have indicated to whom the child was clinging most (M for mother, F for father ; in cases not marked with "M" or "F" the clinging was indiscriminate, to any adult.) A selective clinging to one of the parents could of course only be taken as a clue to a difference in attitudes between father and mother, when both parents were seen together with the child.

As we have mentioned earlier, the clinging often had an impersonal, automatic character of just seeking a "base", as for instance the shoot of a creeper plant will wind itself round any available support. In one case, the lack of emotional contact associated with this compulsive seeking for physical closeness was particularly obvious. In the history of this 8 year old boy we noted : "He is most of the time sitting on someone's hips, clinging like a small baby, but not looking at the person, staring into space." The boy's elder sister reported that, even when he could stay close to a person of his particular choice, he would seldom look at him or her, nor would he ever try to be tender and loving or to communicate by speech. In some of the children, one got the impression that, the moment they had to detach themselves from physical contact with the protecting figure, they so-to-speak ceased to exist and were thrown into panic.

Disturbances of speech were noted in all cases except one. Even in this one case, one could perhaps have marked this column as positive. The boy had very well developed powers of speech and even showed interest in foreign languages. Very often, however, his compulsive questioning, to which he sometimes did not even expect an answer, had the character of securing and confirming himself rather than of really wanting to reach the other person. In all other cases, the children had either developed their abilities to speak very slowly or hardly at all, or, if they could talk, they would only do so in order to indicate urgent needs or for the pleasure they themselves derived from this oral activity. It may be of interest to give a few samples of children's behaviour with regard to speech. Quite a few of our observations correspond to the phenomena which Western authors have described as typical. (See in particular Bosch (8), who presents a very careful analysis of the development and deficiencies of speech in autistic children ! It may be particularly interesting to note that some of the "impersonal constructions" he notes in the speech of these German children, have their current use in Hindi !) We are picking out the examples at random ; they will later also be found in the context of the corresponding case-histories.

One boy of 5, though he could talk, used mainly gestures to indicate his needs. He would repeat songs heard on the radio and automatically imitate what others

were saying, but did not use language spontaneously for the purpose of communication. Another boy of $5\frac{1}{2}$ was reported to "repeat words without sense". One girl of 5 seemed to have developed a kind of "baby language" of her own. The only word one could occasionally recognize, was "Daddy", the figure to whom she also clung most!—another boy of 4 had developed very expressive gestures to which the mother promptly responded. As to speech, he only had a repertory of a few syllables, like "ma" for mother, "pa" for father and "kha" for anything that seemed good to eat. One girl of 7, whose vocabulary was quite rich, mainly used it to talk to herself or then to gain attention, even at the expense of telling lies. The one boy examined at the age of 10, had only started speaking with any fluency at 5. He obviously enjoyed repeating strings of words to himself. He also very happily chanted to himself religious hymns and film songs, but was hardly interested in using speech for communication. A further boy of 5 babbled to himself in his own language, in which only a few words could be recognized. He could occasionally speak a full sentence, when it served the purpose of getting some need satisfied. Several of the children would not even use speech to ask for food when they were hungry.

In our reflections on the few cases of stammering in the neurotic group, we showed that, developing the function of speech, presupposes a readiness to "give" with an organ that during the first months of life is merely designed to "take". While the stammerer's hesitating speech seems to indicate a dilemma between wanting to give and wanting to retain, the autistic child decides for "keeping back" or rather "keeping for himself". In one case we had noted. "He hoards not only toys, but also his powers of speech."

In some of the cases, we got the impression that the children's wishes had always been so promptly fulfilled or even anticipated by pampering or overanxious parents, that they had felt no need to develop speech as a means for announcing their desires.

The two next symptoms on the list, obstinacy and temper-tantrums, normally occur during a certain phase of development, at about the age of 3 to 5, when the child discovers that he can assert his will against other people. In the group of psychotic children, the violent as well as the tenacious method of resisting coercion or of pushing through one's own intentions, was exaggerated either by its frequency, its intensity, its particular character or its persistence beyond the age at which one would normally have expected it. In several of the children, we were able to witness violent temper tantrums during consultation.

The most amazing performance was given by a thin, asthenic-dysplastic little boy of $4\frac{1}{2}$. When the mother refused his wish of sitting on her lap, he went into a fit of kicking, biting, pinching and screaming. Sitting on the floor, he would prop himself up by both hands and, supported and suspended by his thin arms, he would lift himself up several inches from the ground and then thump himself down onto his seat. He repeated this in rhythmical fashion and with such violence, that one expected him to be bruised all over. He appeared like a nasty little dwarf completely possessed by rage.

Another boy, aged 5, burst into a fit of temper, when he was not allowed to take the chalk with him from the play-room. He tore open his bush-shirt and kept flapping the two front parts like wings, crying in fits and starts. His father remarked that, at home, where he probably felt less embarrassed, he would completely tear off all his clothes during such fits of rage. He seemed to continue the demonstration automatically, long after he had forgotten what originally released it.

Stereotype repetitive movements can be observed in many autistic children. They are particularly described in small children who have been deprived of the stimulus of maternal care and love during their first months of life. Unable or refusing to respond to stimuli from the outside world, they probably have to discharge their motor energies in some way that will not engage them in real action and that will not produce any change. While the ability to move assures one of one's being alive, the repetitiveness of the movement gives the security that things remain as they are. In children who have no great hesitation in using speech, the repetitive performance may consist in reciting some stereotype string of words, singing some song or in repeating the same question over and over again.

One boy, aged 5, kept waving one hand sideways and took great pleasure in rhythmically kicking his feet against the doctor's hand. Another boy, aged 4, kept turning his hands before his eyes or scratching his head and pulling his ears in automatic fashion. At times he would even beat his head against the floor. One boy, aged 5½, according to his mother, would wave a branch or gaze at some running water or some birds for long periods. The eldest child, the girl aged 11, equally seemed to freeze in some position rather than to persist in stereotype action. During the interview, she kept standing stiffly nailed to the spot, head bent down, hands in her pockets, apparently wavering between approaching the toys spread out before her and keeping her aloofness, a form of behaviour closely approaching that of adult catatonic patients.

Aggressiveness and destructiveness, formed part of the temper tantrums in some of the cases, but were also noted apart from them in about half of the children.

Anxiety may have been a subjective feature in all of the cases ; but it was more distinctly manifested in 6 of the children. Examples will be found in the case-histories.

Lack of toilet training was signalled in 8 cases, while in 2 further ones we had occasion to note excretory symptoms during consultation. The incontinence often did not seem to be the consequence of a genuine lack of control, but in some cases had the character of a wilful carelessness or even a pleasurable performance. One boy of 4 was reported to urinate into his plate while eating. The one boy whom we were able to observe over a long period, went through a phase in psychotherapy, during which, at the age of 10, he quite deliberately urinated into the therapist's lap. The same boy repeatedly expressed his wish to eat his own faeces. Another boy, whose parents had not complained about any incontinence, during one of his few interviews, was observed to walk along the corridor while urinating in a vigorous jet, obviously enjoying

his performance. Two of the boys, one at the age of $4\frac{1}{2}$, the other one at 10, were observed to masturbate frequently and in a quite shameless way.

Strange habits with regard to food were reported in 10 cases (noted under the heading "food-fads"). Some of the children were described as "greedy" and "grabbing", others, on the contrary, did not seem to care for food, never asked for it or even refused, what was offered to them. One boy of 4 insisted on taking only milk. Two little girls took pleasure in eating mud, coal or chalk.

The sleep disturbances noted in 5 cases consisted mainly in restlessness or night terrors. One little girl seemed to keep deliberately awake at night, talking to herself.

While most autistic children hate change and want to keep things as they are, more specific signs of "neophobia", *i.e.* fear of anything new, occurred in at least 5 of the patients :

One boy of $5\frac{1}{2}$ was described to object to any change in his environment, including the mother's dress. One girl was observed to cling anxiously to her father, whenever any new toy was shown to her during her visit. One boy strongly protested against having any of his old clothes given away. The patient who came for psychotherapy over a prolonged period, hated to see any item in the playroom moved from its usual place. Any pattern of behaviour, often of a stereotype nature, was kept up by him for a long time and only very gradually allowed to be superseded by any new interest.

This same boy also had some compulsive habits. At home he would very carefully arrange all articles in the bathroom in a quite particular order. On coming home from school, he had to touch certain objects in every room, a behaviour rather reminiscent of the way in which certain animals have to "mark" their territory with their excrements, so as to make them their own. During his interviews, we had occasion to note that he went into furtive compulsive performances at moments when some anger and anxiety threatened to overwhelm him. Once, when he expressed, even in disguise, some hostility with regard to his father, he quickly offered to recite his "tables" immediately afterwards. When one interview was disturbed by the wild screeching of some monkeys in the garden, he looked terrified and seemed to find some relief in going several times to the wash-basin in order to touch a particular towel. It was interesting to watch, how his compulsions increased, whenever he went through a phase in which, for some reason, he tried to suppress his aggressive tendencies.

Similar compulsive symptoms, though not so well observed as in this particular case, were reported only in one case, while in 3 further cases, mild compulsive tendencies were present.

In 4 children, we were able to observe their attempts at "grabbing" and "hoarding" the toys in the playroom. One boy of 4 spread out his mother's handkerchief on the floor and started packing all the wooden blocks into it. He got angry, when he was

not able to tie up his bundle, because he had piled up too many bricks. This boy was quite ready to take anything within reach, though not with an intention of using it, but merely of possessing it.

Other characteristic types of behaviour observed during play will be communicated in the context of the individual case-histories. In general, what we could note during the scarce opportunities we had of watching the children, corresponds to what other authors describe : a tendency to perceive and use objects not according to their functional meaning, but to register and perhaps sort or collect them according to mere external attributes, like shape, size, colour.

The synoptic Tables (Table 22 A and B) indicate, in the middle columns, between the two sections, how frequent the various symptoms were in the children who showed organic signs of brain-damage as compared to those without neurological symptoms. The only significant differences seem to be that withdrawal, obstinacy, stereotype movements, aggressive and destructive tendencies, are more frequent in children with signs of brain-damage, while clinging, temper-tantrums, neophobia, compulsions and hoarding of toys predominate in the children without such signs. The frequency differs most for stereotype movements, with a ratio of 62.5 per cent : 33.3 per cent, which suggests that some lesion of the cortical motor areas may have released primitive subcortical mechanisms in the brain-damaged children. Most of the other differences are not so marked that one can completely exclude mere chance.

Any particular correlation of any symptom with one or the other aetiological factor is not rendered obvious by our material.

While this enumeration has given some idea of the nature and variety of symptoms as such, they will of course only assume their proper place and dimension within the framework of each case-history. One may, however, already now have realized that the symptoms mentioned constitute severe deviations from normal behaviour and that they all seem to aim away not only from true human communication, but also from facing change and growth.

(4) *Local Origin* (Table III).—Of the 16 Indian children, only two came from a village. The one Nepali boy, however, is also of village origin. Three of the children came from small country-towns; they have been marked in Table 21 with (x) in the column for "village". While these latter 3 all belong to the group with signs of brain-damage, only one of the children from a village presented neurological symptoms. Of the remaining 2, however, the one was handicapped by partial deafness, while in the other one, 6 of the "constitutional" factors were positive. We mention this, because the presence of children from "unsophisticated" surroundings in this group of infantile psychosis contradicts the observations of certain Western authors. It may therefore be of special interest to state, what other factors, if not the intellectual emancipation

and emotional distance of highly educated parents, can contribute to provoking an autistic response. We shall sum up the 3 cases of children who lived in villages :

- (110) *Sajjan*, who is to be found towards the "functional" end of the scale on page 303, was brought to us at the age of 5. His father was a Baniya business man in a village at some distance from Lucknow. No cases of mental illness were known in the family. The parents, apart from their pampering and overanxious attitude with regard to this eldest and only son, seemed to be fairly well-balanced. The family was joint one.

The boy, born as the first child, when his mother was aged only 16, the father 21, was followed by 2 sisters, one $1\frac{1}{2}$ years younger, the other one 3 years younger. Breastfeeding was presumably stopped, when the next child arrived, *i.e.* at the latest after $1\frac{1}{2}$ years.

When, at the age of 3, the boy had not started talking yet, the parents began to worry. They noticed that he was hard of hearing. When they brought him for consultation at the age of 5, they complained about his stubbornness and temper tantrums, his restless, mischievous and destructive behaviour and his lack of concentration. He was still wetting his bed and at times grinding his teeth in sleep.

Apart from the slight deafness, there was no evidence of any physical weakness. He was sturdily built and had not gone through any severe illness.

During one visit, we noted his restless, hyperactive behaviour, his irritability and his indistinct speech. He was interested in toys, inquisitive and quite skilful in any manual performance. When shown some marbles, he put them into his pocket.

Sajjan is probably the case in which the autistic features were least typical. We got the impression that his reluctance to use speech was not only a consequence of his slight deafness, but just as much of his having been pampered to the extent of never even having to formulate his wishes, as they were fulfilled automatically. The emotional immaturity of the young mother, who, though she was sheltered within a joint family, seemed to be rather anxious about the boy, may have contributed to his abnormal behaviour.

- (111) *Sitaram*, son of a Baniya mill-worker from a village near Lucknow, also was the only son. The eldest child, a boy, born before the mother was aged 20, had died at the age of 3 weeks. One sister, 6 years elder than our patient, was well developed.

We know that one paternal uncle was mentally ill. The family was probably a joint one ; but we have no certain information. The father had suffered from

chronic eczema, which possibly could have been a psychosomatic affection. He told us that, formerly, he had been very short-tempered, but that recently he had become more religious-minded. He was very concerned and anxious about his little son. The mother was described as sickly, short-tempered, and self-willed. Since the birth of the youngest child, our patient, she had suffered from "heart-trouble" and fits. It looked very much as if, after having fulfilled the duty of giving her husband a surviving son, she wanted to excuse herself from all further tasks and obligations. She had delegated most of her household duties to her daughter, though the girl was only 10 years old, and she was thoroughly "fed up" with her troublesome little son.

Already while pregnant with the boy, the mother felt her "heart trouble", possibly consisting in palpitations as a sign of anxiety. During the 6th month, some bleeding occurred. In spite of this, delivery was normal, but the child was weak and sickly. A few months after birth, he suffered from chicken-pox and, at the age of one year, from a dystrophic state, probably rickets. During this illness, his body was noted to "jerk" at times ; but no actual convulsive fits with loss of consciousness occurred. He learned to walk at 2. At the age of 4, he could only pronounce a few words. He still sucked his mother's breasts. Whether he actually got any milk, is not known. As a substitute, he would occasionally suck his toes. Apparently he had learned to take solid food. He is the child who was reported to urinate into his plate while eating. He was generally fidgety and restless and at times would run out of the house.

Physically, he looked younger than his age, and his body still had retained its babyish proportions. The head was somewhat bulky, with massive protuberances in the occipital and parietal regions. The tonus of the limbs was rather loose. No definite signs of brain-damage were found.

In the play-room, he did not show any persistent interest in any toy. He would push about some small railway carriages or pile up some bricks and quickly destroy again, whatever he had built ; but in between these hasty activities, he again and again ran out of the room in order to roam about or to cling to his father like a little monkey. When we tried to hold him back in the play-room, he went into a fit of temper, crying furiously, so that his face became all purple with rage.

The parents confirmed our suspicion that this only son had always had his will done and that he had been given no chance to wait and to bear frustration. Though the mother seemed to have developed a rather negative attitude with regard to him, she could not bear to see him frustrated and would rather fulfil his wishes immediately than to hear him crying. The father also pampered him like a small, helpless baby. The boy showed signs of quite shrewd intelligence. But he quite obviously only used it to gain his own purpose. The use of speech did not seem to be necessary, as he had developed quite clever manoeuvres for

getting what he wanted without having to ask for it explicitly. In the synoptic table (Table 22), this case is listed first in the group of children (B) without neurological signs. 6 factors may be taken as having had some influence on his constitution and his physical powers of resistance: the disturbed pregnancy, weakness after delivery, the presence of mental illness in the family, the neurotic behaviour of the mother, which included autistic features, the early death of one brother, his having gone through rickets at the age of one. Environmental factors, apart from the rejecting attitude of the mother, the overanxiousness of the father, both concealed by a superficially pampering overconcern, were the boy's position as the youngest and the only son and the continued access to the mother's breasts up to the age of 4. If we had had a chance of exploring the family atmosphere more thoroughly, we might have found even more harmful influences.

- (112) *Prakash*, the 4 year old boy from the border region of Nepal, was the son of a Brahmin farmer. The family was probably originally a joint one; but at the time when we got to know it, relationships seemed to have become rather complicated:

The father, who seemed to be of somewhat limited intelligence, had taken a second wife, after his first spouse had already produced 4 children, 3 of them surviving. This means that he did not have the excuse of the wife's barrenness for his polygamy. The two women first lived together in the same household and both went on producing children. Of the first wife's further issues, 3 more survived, while one girl died, bringing the total number of living children up to 3 sons and 3 daughters. *Prakash's* mother, the second wife, by the time we met her, had given birth to 5 children. A first daughter died of "fever" at the age of 6 weeks. A next child, a boy, died at the age of $2\frac{1}{2}$ months of fever with convulsions (encephalitis?). A third child, also a son, had died of cholera at the age of 6, about 8 months before the consultation. Our patient was born shortly after the first wife had also delivered a son. One younger brother, of the same mother, was aged 7 months, when we got to know the family.

Already before the patient's birth, the 2 women, who obviously could not live peacefully together, had set up separate households. The insecurity caused to *Prakash's* mother by this awkward situation, was increased through the death of both her parents, just at the time when she was pregnant with this child. She furthermore was sick with "flu" during that period. One month before *Prakash* was born, the other wife stole the limelight by giving birth to her son. To judge by all we know, the mother, in her insecurity and depression about the loss of her parents, did not pay much attention to the baby. He was breastfed partially up to the age of 2. He often suffered from fevers and minor infections and only started to walk at the age of 3.

When the parents brought him for consultation, they mentioned that, up to a few months ago, he had hardly ever looked at anyone. He would only sit and

move his hands or beat his head in stereotype manner. At times he would beat his mother. When hungry, he would weep. All food except milk was refused, and even this was taken very slowly and hesitatingly. The only word he had learned to utter was "amma". He would laugh, when beaten or scolded and, without any sense of danger, would let himself fall from his cradle. Since the arrival of the younger brother, 7 months before this consultation, he had shown a little more signs of seeking communication. He showed obvious jealousy with regard to the baby, whom he tried to beat and push away.

Physically, the boy was severely underdeveloped, looking like a child of 2 rather than his chronological age of 4. The big skull contrasted rather strangely with the thin limbs. All over the body, we found signs of recent boils. On plantar stimulation, both feet reacted with dorsal extension. His facial expression was alert and mischievous, certainly not that of a mentally deficient child.

While, at times, the little boy would run about in very agile manner, one could observe him, at other moments, sitting quietly, turning his hands before his eyes, scratching or beating his head, picking or pulling his ears. At times he would even hit his head against the floor in rhythmical, stereotype manner. Whereas he obviously took no notice of any other human being, the mother at least seemed to have some value as a refuge. At times he ran towards her to hide in her saree. In the playroom, all he did in between his bouts of running all over the place, was to throw about the wooden blocks in careless fashion. In this case, a vicious circle seemed to have established itself, starting probably with poor genetic material, then lack of attention by the insecure and depressed mother in early infancy, moving on to trophic disturbances and inhibition of physical development, resulting in autistic patterns that further reduced human contact and also prevented healthy nutrition.

The one common element in all these 3 cases from villages, is that the boys were eldest or only sons. The parental attitude, though certainly harmful through excessive pampering, which, however, in one case disguised overanxiousness and rejection, or then neglect, did not correspond in any way to the description of Western authors of sophisticated, emotionally cold parents. The only link between these simple village people and the emancipated parents of the West may be that their own concerns, what they would gain out of the child by way of interest, satisfaction, pride, was more important than the child's true need for help in growing into a human being in his own right. How much these parental attitudes might have sufficed by themselves to produce an emotional distortion, and how far they were met at least half-way by the sensory deprivation of the deaf boy, the deficient constitution and the dystrophic states in the two other children, is difficult to decide. The fact that the children from country-towns, whose parents also were not of the sophisticated type, all belong to the subgroup with signs of organic brain-damage, could possibly be interpreted in the sense that only the extreme intellectually cold attitudes observed in the Western parents

of autistic children are apt to produce the disorder without the base of a constitutional weakness or definite brain-damage.

None of the children in this group had been subject to migration or the fate of a refugee.

(5) *Community and Caste* (Graphs II and III).—The group of infantile psychosis, though big enough to allow for at least a sprinkling of children from other religious communities according to the mere laws of chance, only contains children from Hindu families. This again raises the question, on which we have already tried to throw some light earlier, whether there is anything in Hindu culture that would promote the tendency to psychotic reactions and in particular to autistic patterns.

Withdrawal into the self, a turning inward of the senses, an interpretation of outward events merely in terms of one's own karmic involvement, denial of individual limits and forms as mere play of "maya", attempts to reach the formless, unborn, unlimited, are indeed typical for Hindu philosophy. It would, however, be absolutely wrong to set the aims of these highest philosophical and religious aspirations as equal to the crippling isolation or the chaotic lack of boundaries of a schizophrenic adult or an autistic child. All we can perhaps say is that, in any culture shaped by certain philosophical or religious ideals, not only the highest human attainments, but also the saddest shortcomings can be determined or merely tinted or possibly even disguised by the prevailing ideology. While this ideology may have taken its origin from a certain fundamental human attitude particular to a race at a certain period, it will, in its turn, again imperceptibly influence the climate in which later generations grow up. Thus, in the Christian world, with its ideal of loving one's neighbour as oneself, the most unreligious forms of selfseeking exploitation or self-forgetting extraverted busy-bodding may hide themselves under the same ideals which have inspired examples of true care and devotion to suffering fellow-beings. Similarly, the search for the "Self" as prescribed by the old Hindu scriptures, may not only lead to highest wisdom and mental peace, but, if misunderstood and used in the service of regressive tendencies by an immature mind, can lead to barren stagnation and self-mutilation. While the real breaking of worldly ties and boundaries, which presupposes that these ties and limits have been experienced and accepted at their proper time, ought to lead to freedom from anxiety, from hatred and from need for concealment (perhaps all terms that can be summed up by the Upanishadic notion of "vijugupsa"!), to a willingness to be the shelter and caretaker ("ayatana" or "bhutapal") of other creatures, autistic withdrawal or indiscriminate symbiotic merging are escapes beset by constant anxiety and by a fundamental unwillingness to grant a place, a world, to any other being.

With this caution in mind, one may be allowed at least to pose the question, whether, possibly, the prevalence of psychotic reactions in Hindu adolescents and children and the relative frequency of mere neurotic reactions and infantilism without significant autistic distortion in Muslims, may have any relationship with the

religious attitudes dominant in these 2 cultures. Of course, as we have mentioned earlier, other cultural factors of a lower order also may have their influence. They, however, may in their turn again have been shaped by a fundamental ideology. Furthermore, we again have to consider the possibility that the difference in the number of Muslim and Hindu patients in various diagnostic categories examined by us, may not reflect the actual incidence, but only the tolerance or concern with which certain forms of deviant behaviour are viewed by parents of the two different cultures. On further investigation, we might well find that Muslim homes with their frequent in-breeding through cousin-marriages and their atmosphere of seclusion and secretiveness may hide just as many autistic children as the Hindu environment, but that the parents perhaps may not regard such aberrations as worth consultation. We have seen several Muslim women, some of them of quite advanced age, who wanted a further baby quite obviously either for the satisfaction of some personal pride or in order to protect themselves from anxiety and loneliness. Possibly the distance which some Muslim fathers keep with regard to the "zenana" may allow a mother to continue in her clinging symbiosis with a child without the interference of someone who would consider the child's development as pathological. The mother herself, whose attitude is often closely matched by the child's deviation, is not likely to seek psychiatric help. The fathers of both postencephalitic Muslim children with autistic features and of the 20 year old girl who had passed from infantile autistic patterns into hebephrenia, were all careless, distant, and insignificant figures. Attitudes that might foster autism in children are certainly not lacking in Muslim parents. The question may be, whether either some constitutional peculiarity or some environmental influences tend to mitigate or to counteract their effect on the children or whether any possible autistic reactions simply remain concealed behind the thick curtains of the women's quarters.

Whatever the theoretical explanations may be, the fact remains that our group of "infantile psychosis" is made up completely of Hindu children. Amongst the infantile children with autistic features, one is a Muslim girl; of the postencephalitic children with autistic tendencies, 2, *i.e.* 50 per cent, are Muslims. One of the 2 older adolescents, in whom hebephrenia seemed to have developed from autistic patterns in infancy and childhood, also is a Muslim girl with a very rigid, autistic mother.

Within the Hindu community, the distribution of the psychotic children between the various castes shows a predominance of Brahmins (6 and, including the one Nepali child, even 7). Baniyas take a second place (4) and Ksatriyas and Kayasth (3 each) are equally represented. The presence of 18.7 per cent Kayasth children is in contrast to all other functional groups, in which Kayasth children are either completely lacking or only rare. One may wonder, whether the fact that all 3 Kayasth children belong to the sub-group with signs of organic brain-damage may have anything to do with the greater frequency of patients from this sub-caste in the organic congenital groups, in particular that of epilepsy. Of the 3 other castes, Brahmins are more frequent in the sub-group of psychotic children without signs of brain-damage, which also contains all Baniya children, while Kshatriyas are slightly more frequent in the sub-group with

neurological symptoms. These figures may of course be due to chance ; but one cannot quite exclude that variations in certain cultural patterns between the different castes or even some particular constitutional bias may actually exert an influence in favouring autistic development either only on the basis of organic brain-damage or even without it.

(6) *Occupation of Father or Guardian* (Graph IV b).—According to Western theories, which stress the importance of intellectual emancipation in parents of autistic children, one should expect to find an unusually high percentage of fathers engaged in academic professions or higher ranks of service. We find indeed a portion of fathers from this class which, with 37.5 per cent, not only exceeds the general average of 21.6 per cent for all children considerably, but is the highest amongst all groups. It is equalled, absolutely, by the number of fathers in lower service positions. Considering, however, that the latter are presumably far more numerous in the general population, we can undoubtedly assume a relative predominance of children whose fathers belonged to academic professions or higher ranks in service. Of these 6 fathers, 4 were university lecturers or professors, one a lawyer, one in a high position in Police Service. Business families are slightly less frequent than the general average.

The only child who came from a farm, was the Nepali boy ; being a “foreigner”, he is not marked in Graph IV b. As in the group of infantilism, the class of craftsmen and labourers is not represented amongst families of psychotic children. Again one might ask, whether this corresponds to an actual incidence and whether, perhaps, the closeness and almost “animal warmth” of the family atmosphere amongst more primitive people without aspirations towards literacy and higher education, may prevent or at least conceal the development of autistic features in children.

(7) *Joint and Individual Family* (Graph V).—The percentage of children who were known to come from joint families, does not exceed the general average significantly and remains considerably below the corresponding figures for the groups of neurosis and adolescent psychosis.

One case-history, that of the slightly deaf boy Sajjan (110), who came from a village, has already been given. In one boy aged $5\frac{1}{2}$ (118), living in Lucknow, the most decisive factors seemed to be his mother's emotional and intellectual dullness (see later in the paragraph on parental heredity) and his position as the eldest child, associated with jealousy of the younger sister.

A third boy, aged 10 (113), came from a small country-town. He presented signs of organic brain-damage and slight malformations. 3 siblings had died in infancy. He himself had gone through typhoid and had lost his mother, as a victim of the same illness, when he was aged 5. Sibling rivalry and prolonged breastfeeding may have played an additional role. His case-history will be found in the next paragraph, as an example for lack of parents.

Just as for the village children, we thus find that these children from joint families were exposed to a variety of factors that may have encouraged their autistic patterns. In none of the cases, however, any particular information was given that would have pointed to a multiplicity of parent figures as an obstacle to ego-identification. Only one of the children, whose contact with the mentally dull (possibly schizophrenic) mother was disturbed, showed evidence of clinging and, quite significantly, with regard to the father only. The deaf boy tended rather to withdrawal, while the last mentioned boy, who had lost his mother, definitely lived in his own private world.

It is quite possible that empathic-symbiotic forms of clinging and retarded development in children still fit in snugly with the atmosphere in traditional joint families, where the need for clearly defined ego-boundaries hardly exists. So, unless the children have to emerge into spheres of life in which patterns of this kind contrast with the need for individual consciousness and responsibility, *e.g.* at the age of school entry or on leaving home during adolescence, their behaviour may not reach psychotic dimensions or, even if in the eyes of a Westernized observer it should present "abnormal" features, it will not "stick out" as extraordinary within the setting that has fostered it.

(8) *Lack of Parents* (Table VI).—The table on lack of parents only indicates a figure of 12.5 per cent for the group of infantile psychosis, including the one boy whose mother had died and a girl whose parents lived separately. If, however, we understand by "lack of parents" also other irregularities of family-life, such as working or studying mothers, and if we furthermore also count the Nepali boy, whose father divided his time between the separate households of his two wives, we arrive at 35.2 per cent of situations in which the child did not enjoy the regular presence of both parents.

Strange enough, in the one case in which the mother died, we were told that the boy had developed rather better since her death. Even so, he still presented some typical patterns of autistic behaviour at the age of 10.

(113) *Rajendra's* father served in the fire-brigade of a small country-town. His wife seems to have given birth to her first children at a very young age, before she was aged 16. Two first daughters died, one in early infancy, the other one at the age of 4. A third child, a son survived. By the time we met the family, this elder brother was a graduate, aged 23 and engaged in service. A next daughter again died in infancy. When Rajendra was born, 13 years after the only surviving brother, he therefore almost had the position of an only child. At birth, nothing abnormal was noted. On physical examination, however, we found a slightly deformed palate and some asymmetries of tonus, reflexes and motility that suggested brain-damage. Though the latter may possibly have been a consequence of typhoid, sustained at the age of 9, it is much more likely that, as the slight dysplasia, it was a sign of a disturbed embryonal development. Up to the age of 5, the boy suffered from frequent bleeding from the nose and, up to the age of 9, (*i.e.* already before the typhoid !), of excessive salivation, which can be a sign of extrapyramidal disturbance.

The boy was breastfed upto the age of 3, when he had to give his place to a younger brother. At that time, he had not learned to walk yet, but only crawled. He could move about independently at the age of 4 and started talking at 5.

Just at about that time, his mother died of typhoid. As we already mentioned, her death does not seem to have affected the boy much ; on the contrary, we were told that he developed rather better after it. Possibly some mutual clinging may have prevented his growth ; possibly, by the time she died, resentment against her attention for the younger brother may have determined a negative attitude with regard to the mother, so that her death gave him the satisfaction of seeing the younger brother equally deprived.

At 8½, the boy was sent to school. Though he did not profit much, he usually attended class quite willingly ; but whenever, for some reason, he was not inclined to go to school, nothing on earth could move him to do so.

It seemed to be the elder brother, emancipated through his college education, who began to get concerned about Rajendra and who took the initiative for bringing him for consultation at the age of 10. This may point to the fact that, within a joint family of low or moderate educational standard, certain forms of behaviour which strike a more individualistic outsider as abnormal, may be tolerated for a long time.

At the time when we examined the boy, he had learned to speak quite well and, according to his relatives, was even "talking too much". By this, they apparently meant that he was using speech in a playful, repetitive manner without any "sense". He was described as forgetful and obstinate, very fastidious about his clothes and about good food, and highly hyperexcitable. He was easily scared by loud noises, and any emotion, even a joyful one, would make his whole body tremble with excitement. When he wanted any of his wishes to be fulfilled, he would go on tenaciously insisting on it in repetitive fashion, until he got what he wanted.

Whereas this description given by the relatives might still have justified the diagnosis of a merely neurotic disorder, perhaps on the basis of slight brain-damage, the boy's behaviour during the one interview revealed some typical autistic patterns :

In the play-room, he showed some interest in the wooden blocks. When, however, the younger brother interfered, trying to claim some of the toys too Rajendra shrank back and withdrew. After we had sent the little intruder out, the patient started laying out some kind of "crazy-paving" on the floor. In this activity, he demonstrated very instructively the autistic child's attitude to objects as things that are characterized by their outward attributes, but that are not respected in their intrinsic functional value. In order to extend this "crazy-

paving" over as big an area as possible, he did not only use all the building-material at his disposition, but also the railway carriages, which he put on their side to fit them in. It was not that he had not recognized their purpose. Later, when it suited him, he picked them out and rolled them about on the very platform of which first they had formed part. In a similar way, he fitted the chalks meant for writing into his paving. Later, he piled blocks on top of each other in hazardous manner, commenting each tumbling down of these perilous structures by excited laughing. At times he would start some construction in a quite systematic fashion, but soon give it up for some haphazard procedure.

Behaviour of this type, observed not only in autistic children, but also in adult schizophrenics, *e.g.* in occupational therapy, often seemed to indicate their interest in reassuring themselves, that they were capable of a "normal" performance. But once they had satisfied themselves about this possibility, they would hasten to spoil what might eventually have resulted in something "useful" to anyone else ! Activity is sought not in order to produce anything serviceable to the common world of men, but merely for personal gain through release of energy and the pleasure associated with exercising one's physical functions and skills.

At times, our little patient would go into frantic orgies of such activity : he would ring a small table-bell with one hand, while with the other hand he tried to arrange some plastic "saucers" according to size. Only towards the end of the interview we could gain his attention for a performance test. He first was puzzled by the task of fitting small squares with a certain number of holes onto the corresponding pegs and finally accepted some help. In our history we noted : "It is obviously beyond his power of attention and grasping that each thing, in a certain setting, can have its proper place. He is more interested in random constructions and variations." One would hardly be surprised, to find the same two sentences in a critic's remark on certain modern forms of abstract art, which indeed have much in common with the productions of autistic children and adult schizophrenic patients !

While playing, the boy constantly kept mumbling repetitive words or bits of sentences or, singing to the tunes of religious hymns or film-songs, he would often invent his own text. Again, language was not used for its functional value of communication, but merely as a pleasurable "exercise". He seemed to be quite content and perfectly absorbed in his own activities, oblivious of the presence of the psychiatrist. Only when the latter, attempting to meet the boy on his own ground, also started clothing her occasional remarks into the form of songs, he responded with some signs of amused recognition and pleasure. A certain compulsive interest in keeping things in a strict order, was displayed when, at the end of the interview, without being told, he tidied up all the toys and building materials.

It is remarkable that the only 3 cases in our whole material, in which the fathers had taken a second wife, though the first one had not been eliminated by death or legal

separation or divorce, are all to be found in this small group of infantile psychosis. One of them, the Nepali boy (112), has already been summed up. His mother was the second wife, feeling insecure in her position, particularly after her parents' death, as the husband continued to keep up good relationships with the first wife.

- (114) The mother of *Meera* is an example of a first wife displaced from her rightful position by a second union. When the father, a Brahmin college lecturer, was aged about 34, his first wife, then aged about 31, and already the mother of 4 children, 2 of them surviving, fell seriously ill. Possibly because the husband doubted her recovery, possibly because the only 2 surviving children were daughters, he took a second wife, aged only about 15 years. Soon after this second marriage, the first wife, who recovered from her illness, gave birth to 2 surviving sons, thus triumphing over her rival who, during the first 10 years of marriage, only produced 2 daughters, of whom one died.

This was the state of affairs when *Meera* was to be born. During the pregnancy, the mother, aged already 40, was upset by quarrels with her husband, concerning financial matters. The delivery was complicated. While already this 7th child had been unwanted, the mother provoked an abortion, when a further pregnancy occurred $2\frac{1}{2}$ years after *Meera*'s birth. By that time, the relationship with her husband and her co-wife had become so tense, that she went to live separately, apparently at the time, when a first son was born to the second wife. From that union, one more son and a daughter were born later.

Of the father, we know that he was addicted to alcohol and that, when in an angry mood, he would stop speaking for some time. The mother seemed anxious, nervous and attached in an unhealthy way to *Meera*, her youngest child. One felt that, far from providing shelter to the girl, she herself was seeking security by clinging to her.

The girl was breastfed up to the age of 14 months. She started sitting only at the age of $1\frac{1}{2}$, walking at the start of the third year and talking at $2\frac{1}{2}$. She had frequent fevers and digestive troubles and often suffered from some kind of eczema on her legs. At the age of 4, she had a head-injury ; no particular consequences were noted.

When she was sent to school, she could not retain what she was taught and the attempt had to be given up. At the age of 11, she still liked to play with much smaller children. She would never ask for food. When in a happy mood, she would shout and scratch her face in excitement. The person who finally took pity on the child and brought her for consultation, was one of her elder sisters. While this girl, at 23, was a very independent and efficient graduate and social worker, the eldest sister, who was married, looked plump and inert ; at the age of

29, she had never menstruated yet. The 2 brothers, aged 16 and 19, seemed to be bright in their studies.

Physically, the girl was delicate, with slightly dysplastic, birdlike features, and slender, long hands and feet. Blood-pressure was remarkably low. Otherwise there were no signs of any particular physical involvement.

The history, as well as the first impression one got of the girl, might have tempted one into assuming a simple mental deficiency. On closer observation, however, this diagnosis did not seem to be justified. Neither the frequent lack of inhibition nor the dull apathy of an imbecile characterized her behaviour. She seemed to be far more frozen into inactivity by a tense interlocking of ambitendent impulses. When she was taken to the play room, she kept standing stiffly, with head bent, hands dug into her pockets, for almost a quarter of an hour. Then she seemed to be attracted by a colourful plastic peacock, and one could see, how the wish to approach it and the fear of contact struggled against each other. A few times her fingers and toes showed just traces of movement ; then she would start to bend down, but check herself and stand motionless again. Once she actually reached out for the toy, but immediately dropped it again. After a full 15 minutes of inward struggle, she took a deep breath, picked up the peacock and squeezed it, then dropped it again. When she saw the coloured chalks, she hastily grabbed them, but only to put them into her pocket. One thing was obvious in her whole behaviour, even when later she was a bit more relaxed : she would never take interest in an object at the time when anyone challenged her. Either she would refuse attention altogether, or then she would show it at her own time and in her own, often quite distorted fashion. On her own, she started to sort out the wooden blocks according to colour. When the psychiatrist made an appreciative remark about this, she desisted from this relatively ordered activity and went into random combinations. In tests which required some sorting out according to form and colour, she quite obviously knew what she was supposed to do ; but she seemed to use this knowledge only for the purpose of acting absolutely against it. Finally she tried to build some houses with the wooden blocks. All her structures were completely closed, without any doors or windows, —reflecting her own tightly closed state!

Later, when her examination was over, we saw her snuggled up like a baby in the lap of her mother who, in her turn, was anxiously clinging to the girl. As the father was living with his “other family”, and the elder siblings were of an age at which they had left home for marriage, work and studies, the girl was exposed to the ageing mother’s overanxious possessiveness without any mitigating or counteracting influence.

- (115) *Ravindra*.—In the third case of “bigamy”, the father, a Brahmin in a high academic position, had removed his first wife and her grown-up sons, so that

the second union, though formally a simultaneous one, rather resembled a re-marriage after separation or divorce. Ravindra, our patient, was the only child of this second marriage. The mother, who had fascinated the father by her artistic gifts, continued her career even after the child was born. Delicate, ethereal, unconcerned about the necessities of daily life, which she left to the servants, she seemed to feel rather insecure in her unconventional position. The child was obviously a token for the firmness of the marriage and, at the same time, a kind of refuge from the husband's outbursts of temper. While the boy was on one hand exposed to the ambitious expectations of the already grey-haired father, who wanted him to grow up quickly, the mother, on the other hand, feared nothing more than his developing into a "boy" or even a man, of whose sex she would have to be conscious in her clinging attachment. But even in her attempts at keeping this only son an innocent baby, her artistic refinement never granted him any outlet and a legitimate place for an infant's instinctual needs. Prematurely toilet-trained and brought up to be a well-mannered "drawing-room child", he had on one hand access to the world of the adults, which gave him a precocious and guilty knowledge of erotic life, while, on the other hand, if he wanted to keep his mother's protection against the father's unpredictable temper, he had to remain a sexless little angel who would pollute the Westernized home neither by dirt, nor with aggression or even only rough manners or coarse language. One felt that the only security the boy had, his mother, was at the same time the source of the most-threatening and limiting influence, which hardly allowed him a place in which he could move freely in this world.

Pregnancy and delivery had been normal. But the boy presented signs of slight malformation and later suffered from some endocrine dysbalance suspect for pituitary-diencephalic involvement. We know that in the father's family there were several cases of mental illness.

When the child was aged 3 months, both he and the mother fell ill with chicken-pox. According to the mother, this was the reason why she stopped breastfeeding. If it was, it seems to have been a welcome excuse as, seeing her horror of all grossly physical phenomena, one could not help suspecting that breastfeeding too must have been a tiresome and humiliating servitude to her. In order to protect herself against a further "risk" of being drawn into such "low" biological tasks, she had insisted on sterilisation after the birth of our patient.

Since infancy, the child showed a tendency to violent temper-tantrums. At the age of 3-4, he developed fear of darkness and turning fans. When he was first brought for consultation, at the age of 7, he had started annoying and embarrassing his parents by scratching, pinching, kicking and spitting and by compromising them, before their frequent guests, by ill-mannered behaviour. He also objected to being left without his mother, when she went out for her work. His speech was well developed, but he mainly used his rich vocabulary,

both in Hindi and English, and his wide knowledge, in formulating compulsively repetitive questions, which could seldom be satisfied.

During the numerous psychotherapeutic sessions, distributed in 3 main phases over 6 years, not only his suppressed aggression and his frustrated infantile interest in his excrements found a drastic outlet, but we had occasion to observe compulsive habits, fear of anything new and, above all, the quite obvious fact that, to this boy, nothing outside himself really had independent existence, but that the whole world was only seen as a mirror that should reflect his own wishes and intentions. Any unexpected spontaneous move in his surrounding would release intense anxiety. His compulsive questioning partly seemed to have the purpose of keeping the partners in the role of a mere "reactor" to his game and of preventing him from any spontaneous, unforeseen action. By the time the boy was aged 13, this inability to recognize any conscious and independent acting subject beside himself, had developed into quite manifold ideas of greatness, but also into a paranoid fear of being exposed and possibly harmed in his uniqueness.

In this case, it was not only the parents' ambiguous marriage situation and their excessive concern for reputation and social prestige, but also the mother's attachment to her artistic career, of which the boy was intensely jealous, the father's unpredictable anger and the boy's position as the treasured only child, possibly the abrupt early weaning, that superimposed their effect on a constitutionally dysplastic child with a loaded heredity.

While, apart from the case just mentioned, none of the other mothers engaged in work outside the home, two of them, both wives of men in academic positions, had ambitions for higher studies. One would suppose that these cases might come closet to the pattern described by Western authors as typical for the parents of autistic children. In our older adolescent and adult female patients, we have often noted that aspirations for higher studies served the purpose of escaping from such "low" tasks as marriage and motherhood. Many of these girls and women, particularly those who suffered from compulsive symptoms, hardly tried to conceal the fact that they had no intention of ever putting their knowledge to any practical use, but that they were exclusively after "perfectioning themselves" *i.e.* a quite autistic aim. While women of this kind, out of an automatically persisting attachment to tradition and also a wish for security and prestige, still accept marriage and even the necessity for consolidating their position by producing at least one offspring, the instinctive and emotional ties with the child or children are poorly developed or may be completely lacking. Often a pregnancy or the birth of a child is particularly resented, if it falls into a period for which some course of studies or an exam was planned. If the child has a well-balanced constitution or if his intellectual gifts allow the development of a rational defence he or she may fit harmoniously into the academic atmosphere, substituting intellectual pride and satisfaction for fulfilment of emotional needs. This, of course, does not exclude that a breakdown may come in later years, when the talents are perhaps

prematurely exhausted and tasks that require more than book-knowledge have to be faced. The child, however, who is constitutionally handicapped, brain-damaged or left unsheltered by his relative immaturity at birth or who, quite simply, depends for his growth on more instinctual and emotional warmth and closeness, will not thrive in a cold, intellectual atmosphere of this kind.

Let us see, whether in our 2 cases of "studying mothers" we can discover any influence of this kind :

- (116) *Ranjana* was the eldest surviving daughter of a Kayasth lawyer. At the age of 40, when he brought the child for consultation, he still looked very young and boyish. Physically small and delicate, he had an emotionally starved look. He described himself as sociable and friendly, but admitted frequent fits of anger. He was much more loving to the children and particularly to our patient, than the mother. But one felt that he himself, neglected by an emotionally cold wife, did not have much to give. The mother, aged 30 at the time of consultation, though at the beginning of her marriage she had planned to have only 2 children and then to get herself sterilized, had already, very reluctantly, gone through 5 pregnancies. The couple seemed to be either too much removed from the world of practical necessities or too careless to think of contraceptive methods and, whenever the mother planned "to have the operation" immediately after a delivery, she was too weak.

The first child, a girl, died at the age of $3\frac{1}{2}$. The second one, a son, had already reached 4th class at the age of 8. *Ranjana* was the first child who exceeded the planned quota of 2 children. At the time when she was born, her mother was preparing for her first M.A. exam ; so she resented the interruption. One more girl, 3 years younger than *Ranjana*, and a boy almost 6 years younger followed. The father quite openly told us that his wife only attended to the children as a matter of duty, without being emotionally attached to them. Probably even breastfeeding was a duty to her or merely something that saved the more troublesome procedure of preparing special baby food, possibly also an atonement for guilt feelings about neglect in other respects. At any rate, the little girl got the benefit of 2 years' breastfeeding. She learned to walk at 18 months, but only uttered the first words at the age of 3. As the mother continued her studies she did not pay much attention to the baby who, in her turn "did not give much trouble". The parents noted that, when she was sitting at the age of a few months, she used to move her body rhythmically backward and forward.

When, at the age of 3, just after having started talking, the child fell ill with diphtheria, it was the father who accompanied her to the hospital and who looked after her there, as the mother just happened to be at the maternity clinic for the next delivery. After this illness, when of course she had to find the newborn little rival at home, the girl's behaviour became more unusual. By the time she was 6, she

had hardly made any further progress in speaking and seemed to lack understanding for many things. Often she behaved like a small baby, passing urine and stool in her clothes, while previously she had been toilet-trained. She was very active, running about a lot and even at times strolling away from home. She often beat her siblings and destroyed toys. At night she slept little. She had developed some strange food-fads and often could be found chewing mud or coal. She took a certain interest in noise and music and in riding a rickshaw. When in pain or trouble, she would at times shout "amma"; otherwise, whatever she spoke, had hardly any relationship with reality situations.

On examination, we found a small, delicate girl, looking younger than her age. The limbs were thin and slack. While sitting, she went into rhythmical forward and backward movements of the body. A pathological plantar reflex on the left made one suspect slight brain-damage. The girl was agile and no doubt intelligent. But in many ways, her behaviour was that of a child of 15—18 months. When picked up, she would sit on the hips, clinging with her legs round the waist, just like a baby. Even this clinging, however, had no affectionate note. She seemed to take notice of people and objects only as far as they were necessary for the fulfilment of her immediate needs. For her father, who probably had played more of a maternal role than the mother, she showed some attachment. The only word one could occasionally understand when she babbled to herself in her baby-language, was "Daddy". This "private" talking had a good deal of emotional expression, but no recognizable sense. In the play-room, she showed some interest in the wooden blocks. When the doctor built something for her, so as to encourage her, she pulled down the structure. On her own, she then proceeded to pick out all the building elements that had the shape of rounded pillars. First she assembled them in lying position, then stood them up on end, with some attempt at grouping the different colours symmetrically. When all rounded pillars were exhausted, she turned her attention to some blocks that had the shape of half-discs. The more common oblong and cubic blocks were only assembled in a row, when no rounded ones were left. Not only in this game of sorting out, but also in the interest she directed to the toys spread out on the table, one got the impression that only round things were smooth enough for her. As Meera, previously described, she would only take interest in any object at her own time and on her own terms, but not, when it was presented to her. Once she chose to sit on the doctor's lap for some time, but soon wriggled down again.

- (117) *Prahlad*, a Brahmin boy of 8, was one of the most severely disturbed children we had occasion to examine. His father, a university lecturer, was able to provide well for his family financially, but was so much absorbed in his work, that he had no time for his children. The mother kept up her educational aspirations until several years after marriage.

The first-4 children were all daughters. The last one died at the age of 2—3 months. About $1\frac{1}{2}$ years later, just when the mother had got busy studying for B.A., Prahlad was born. Pregnancy and delivery were normal. Though continuing her studies, the mother breastfed him up to the age of $1\frac{1}{2}$ years.

That the mere fact of a mother's breastfeeding need be no proof for her emotional closeness and devotion to the child, was demonstrated to us in instructive manner by some of our adult patients. One woman who went through a depression, which partly seemed to be connected with her disappointment on birth of a third daughter, once insisted on taking this baby, aged about 10 months, with her to the consulting room. There, while talking to the psychiatrist, she carelessly dumped the baby down beside her on the "takhat". When the child, probably scared by the mother's demonstrative wailing, started crying, the mother lifted her onto her knees, pulled up her "kurta" and let one of her ample breast hang down within reach of the child's mouth. She did not make the slightest gesture with either of her hands of holding or supporting the child or of drawing her close, so as to let her feel the warmth of her body. At times she spread her thighs, clad only in "salwars", so far apart, that the child risked to tumble down between them. After seeing this almost mechanized procedure of "milking", the author can easily imagine, how a young mother, ambitious for an academic degree, may let her baby suck her breasts in similar fashion, while she herself is engrossed by her books ! Such lack of loving attention beyond the mere fulfilment of vital needs, however, may foster the autistic attitude of only valuing objects and persons for the use one can get out of them.

To come back to Prahlad's case history : he started walking at the age of 1, talked clearly at the age of 2 and showed signs of great intelligence. Up to the age of 3, his development did not seem to present anything very abnormal. Then he started some digestive trouble. The description the relatives gave, and the residues we found on physical examination (typical bulges on the forehead and slightly O-shaped legs) made us suspect that he probably had gone through rickets and possibly also infantile liver cirrhosis. After this illness, he gradually began to withdraw more and more from any human contact. While, up to that time, the mother had still continued her studies, the boy's abnormal behaviour finally made her quit her books and devote a little more attention to him. The damage, however, had already been done, and the parents' argument that the servants might have scared him with stories of wild animals, only poorly disguised the obvious lack of care and concern which the child had received from them.

When Prahlad was brought to us by his eldest sister and a cousin, at the age of 8, from a city in U.P., the deviations in his behaviour were described as follows : he talked very little and remained withdrawn. He refused to leave the house, to take his bath, and often even his food. When forced against his wish, he would beat shout, and bite. In anger, he could be destructive. Often he would show great anxiety and restlessness. Though he was afraid of leaving the house,

he, on the other hand, disliked being in any small room, as he feared to be locked in. He showed intuitive, irrational likes and dislikes of people at first sight. Some people would make him burst into laughter, as soon as he noted them. In general, he seemed to be more fond of small, delicate, sensitive persons, who probably came closer to his own constitution. Even when he was with people of his own liking, he would seldom look at them and never try to be tender or to talk affectionately. His favourite occupation was looking at picture books in a quiet corner.

Examining the extremely anxious and withdrawn boy, was quite a problem. Almost as soon as he was taken to the play-room, he ran away and stubbornly refused to come in again. He sat on his sister's hips, clinging like a small baby, but not looking at her. He seemed to need almost constant physical contact with one of the people of his choice. At least he had to hold a hand and pull his protector wherever he went. If anything went against his wishes, he would cry, shout and attempt to run away. At times he would utter a few inarticulate sounds but hardly any recognizable word. Later, when he had gained a little confidence in the strange new place, he ran about in the garden in almost dancing manner. The flapping movements he performed with his hands, while tripping about, suggested that he might be imitating a bird or butterfly. Even then however, he never stayed away for long, but after each round came back to his "base" with the sister, as if to collect new energy and reassurance.

The small, delicate boy looked anxious, oversensitive and had an air of genuine suffering. Broad blue veins shone through the pale skin of his thin cheeks. As he was so terrified of any approach, we only managed to test a few reflexes, while he was sitting on the sister's lap. Even then, he would only release one arm at a time for testing, after having secured a firm grip of his sister with the other one. On plantar stimulation, both feet reacted with dorsal extension, which may have indicated a damaged or at least immature nervous system. (The case has been listed amongst the children without sure signs of brain-damage in Table 22, but with a question mark for organic neurological symptoms.)

The rather remarkable fact in this case is that, though Prahlad was the first and only son, born after 4 daughters, his development had not been disturbed by excessive pampering, but rather by neglect. This again shows that a mere numerical summing up of any factor present in different patients can never keep account of the quite particular context and meaning which the phenomenon may have in the individual case !

(9) *Heredity* (Tables VII and VIII).—In all cases in which we had to assume some psychiatric morbidity in the family, either on the basis of information received or of our own observation of accompanying family-members, one or both of the parents were affected by it, either exclusively or in addition to some other relative. In one case,

several instances of mental illness were known in the family of the father, who himself showed neurotic features and was married to an emotionally unbalanced wife. One boy, in addition to his neurotic mother, had a psychotic paternal uncle. One mother who impressed us as mentally deficient, had given birth to a child with a severe malformation of the nervous system (meningoencephalocele), which only allowed survival for 3 days. The sister of one girl, as we have seen, apparently suffered from a hormonal disorder or a malformation of the genitals, which caused primary amenorrhoea. (This case, as not strictly psychiatric nor affecting the nervous system, has not been included in Table VII, but is listed in Tables 21 and 22.)

Even so, "heredity" noted in 56.2 per cent of the cases, or 52.9 per cent, if we also count the Nepali boy, is equal to the figure for "parental heredity". Of course we cannot quite exclude that there may have been further cases of mental illness or emotional distortion in the families, about whom we were not informed.

The synoptic Table (Table 22) shows that, in the children who presented signs of organic damage, "heredity", with 62.5 per cent, is higher than amongst the rest of the group with 44.4 per cent. (See the figure for "parental heredity", as the column for "general heredity" only gives the cases in which some other psychiatric morbidity was also found in the wider family ; as we have already mentioned, parental heredity was present in all cases in which any "heredity" was found.)

Perhaps more than in any other group, the question arises, whether this "heredity", and in particular what we have called "parental heredity", actually takes effect through a biological transmission of defective genes, or whether the emotional distortion of one or both of the parents merely creates unfavourable environmental conditions. The fact that, in most of the families, the same combination of parents also produced healthy, well-balanced children, can be interpreted in either way. Research workers keen on genetics would argue, on the basis of Mendel's laws of heredity, with a "recessive transmission". Those who swear on environmental influences, would probably point out that such factors as position in the sibling row, sibling rivalry, physical illnesses, emotional, intellectual or financial preoccupation of the parents at the time of pregnancy, delivery, infancy of the child may constellate parental attitudes in a different way for each child. Probably we have to assume a concurring effect of biologically transmitted factors and environmental influences. We have tried to express this double aspect, by placing, in the synoptic Table 22, those parents who seemed to present definite psychiatric disturbances, in the section containing constitutional factors under "parental heredity", while the harmful attitudes acting on the patient in particular are listed amongst the environmental factors.

In the case-histories already quoted, we have met several mothers and fathers whom we had considered as neurotic : Ranjana's parents (116) for instance, the father in his infantile immaturity, the mother in her intellectual preoccupation, were counted as such; equally both Ravindra's (115) parents, on the basis of a long acquaintance

with both of them; Sitaram's mother (111) suffered from neurotic heart-trouble and probably hysterical fits. Meera's (114) father was an alcoholic with reactions that approached catatonic patterns, while the mother, in her anxious clinging, obviously betrayed neurotic features.

A case in which the connection between a disturbed mother and the child's autism seemed to be particularly obvious,—though it would be difficult to say, whether on a biological or only on a psychological basis, —is the following :

- (118) *Virendra's* father, a Brahmin, was a clerk in Government Service, educated up to High School. He seemed to be hardworking and affectionate, but used the shortsighted method of bribing his little son into obedience by false promises. According to him, his wife, aged 27 at that time, was mentally deficient and ignorant. He described that she could not even count money and that she was quite incapable of looking after the children and the household. As the family was a joint one, her inability to manage things does not seem to have had too disastrous an effect. When we met the mother, we certainly found her dull and unresponsive. A certain delicacy of her features, an air of childish helplessness, however, made us wonder, whether her "ignorance" was really due to a primary mental defect or rather to emotional poverty and an autistic development.

Virendra was the first child of this marriage. He was followed by a sister, $2\frac{1}{2}$ years younger, who seemed to be developing normally. The boy was born without complications, after an uneventful pregnancy. Unfortunately, we could not get any information about the period of breastfeeding. He only started sitting at the age of $1\frac{1}{2}$, standing at $2\frac{1}{2}$ and walking at 3 years. At 4, he made some attempts at speaking; but at $5\frac{1}{2}$, when he was brought to us on advice of a paediatrician, he seemed to make little use of this ability. While the mother probably hardly registered the boy's peculiarities, the father was concerned about his "lack of intelligence", his restlessness, his deficient control over excretory functions and his utter unconcern about food. The child had developed no sense of danger. At times he would throw away his clothes and toys. When in a mood to do so, he would listen and obey orders. On the rare occasions, however, on which he took the initiative for any activity, nothing could deflect him from it. He frequently performed rhythmical movements of hands and head or repeated "words without sense". At night he only slept for short periods.

The boy, slim and delicate, looked younger than his age. His features appeared sensitive and intelligent and did not indicate any specific "mental defect". He clung to his father with a shy smile and only talked in whispers. At times we observed the rhythmical movement of the hands which the father had described. Neurological examination revealed no signs of brain-damage. In the play-room, he first remained withdrawn and shy. After a while, he linked up the small railway-carriages and made the train move. The father, who had come with him, tried

to interfere in his play by exhorting and persuading him to do things in a certain manner. When shown some dolls, the boy got scared. On the blackboard, he drew some thin lines, using both hands indiscriminately. His favourite occupation seemed to be producing noise by beating wooden blocks against each other.

For a second interview, the boy was brought together with his mother. While the latter was being explored in the social worker's office, the boy approached her. He stopped 2-3 steps away from her ; but the mother did not make the slightest move to welcome him. Both remained motionless at this distance, and there seemed to be no emotional attraction on either side.

This observation of mother and child together, rendered not only probable that the mother was schizophrenic rather than mentally deficient, but also that she had been unable, in her own autistic lack of contact and interest, to provide any healthy stimulus for the boy's development. Mere treatment of the boy, without any attempt at helping the mother or at least at knowing more about her, seemed to be quite fruitless. We therefore suggested that the mother should attend our occupational therapy department, so that we should be able, not only to observe her, but to teach her, how she might gain the child's interest by making toys for him. She came a few times, proved to be very shy, passive, helpless and absent-minded and, after a while, stayed away, as no one at home seemed to be sufficiently interested in this experiment of indirect help.

It would have been interesting in this case to know more, not only about the mother's behaviour and attitude during the boy's earliest infancy, but also about her own childhood and family circumstances. Unfortunately, once again, the short contact with the family and the mother's shyness and reticence, did not allow us to gain more relevant information. The fact that the second child, born not too long after Virendra, seemed to be thriving in the same family atmosphere, makes one suspect that at least a certain hereditary disposition must have made the boy more vulnerable to the mother's lack of emotional interest.

While, in this example, the mother would probably have impressed one as abnormal in any environment, some other mothers showed degrees of mental dullness and emotional immaturity which might have passed unnoticed in the simple atmosphere of a traditional joint family, but who seemed to be out of their depth amongst the responsibilities of an individual household or when having to stand comparison with a highly educated husband and his social circle. Under conditions of this type, even a mother whose intelligence is not or very little below the limits of normal variation, can appear as defective, not only as a matter of comparison, but because the excessive claims may confuse her and paralyse even the moderate abilities she actually has.

As long as the system of arranged marriages risks to bring such unequal partners together, one will not be able to avoid tension and dilemma in the family-atmosphere. On the other hand, as our examples of emancipated mothers may already indicate,

if young people of equal interests join in a marriage of their own choice the self-centred intellectual striving of both parents may create a climate completely devoid of emotional warmth, in which again some children will not thrive.

- (110) *Nirmala* is a child of an ill-assorted marriage between a highly educated university professor and a mentally dull and intimidated mother.

She was brought, at the age of 7, by her father, a well-built, smartly dressed and emancipated man, who, in his family, was the only surviving son. He seemed to be out to prove the child's trouble as purely organic and wanted to deny any tension in the family that could have been responsible for her development. He was extremely reluctant to send his wife for a talk with the social worker and later contradicted most of the information we got from her. We had the impression that he was trying to conceal the vast gap in educational status and mental alertness which separated his wife from him. He seemed to be ashamed of it, not only in front of us, but probably quite generally and, most of all, perhaps, denied to himself that it might be of any consequence for himself and the children.

Our advice was sought by the father, because he considered his little daughter as "mentally backward", unable to learn and lacking concentration. She had not acquired perfect toilet habits yet at the age of 7 and was clumsy in her motor functions. She liked to play with water and often ate mud and chalk. When with other children, she showed herself aggressive and domineering. At night she would keep awake and talk to herself.

The small, delicate girl had a slight squint and her feet were turned inward. The legs seemed rather stiff and responded with pathological reflexes. Her speech was badly articulated and babyish. She seemed restless and anxious and behaved in a capricious, obstinate way. She obviously was out to gain attention by any means. She would even tell lies and make up phantastic stories to gain sympathy. So, for instance, she reported to us that in the English school, to which she had been sent recently, the children were being beaten. She also told us that her mother was studying at the university. As the father had kept discrete silence about his wife's mental limitations, and as the child rather reminded one of a little girl described earlier (Rita, 86), whose mother had been studying and working, we had no reason to disbelieve this statement.

Our surprise was therefore considerable, when the mother, sent on our insistence, proved to be a mentally dull, emotionally poor woman of little education. She was the youngest daughter of a village-teacher and had only visited 7 classes of the village school. Her teeth were deformed, her mouth unsymmetrical, so that her speech lacked clearness ; altogether not a very presentable partner for the smart, emancipated husband.

According to her, she had been living either at her own home or with her parents-in-law, while her husband was still pursuing his higher education. The first 4 children were born during this time, *i.e.* when she only had short contacts with her husband and his emancipated world. 2 of these children died soon after birth. One further pregnancy ended in abortion. Nirmala, at the age of 7, thus had an elder brother aged 18 and a sister aged 12. Both these siblings had progressed quickly in their studies. One sister, 3 years younger, also was described as intelligent. Again according to the mother, Nirmala was born just at the time, when she finally joined her husband in the city, where he had found a post on the university staff. She admitted that, finding herself in academic society, was a very embarrassing experience. The tasks of an individual household and the lack of reassurance and support by older family-members, reduced her security even more. All this information was later contradicted by the husband, who even gave a different order of the ages of his children. Behind his protests, one felt the tendency to prevent at all costs, that any blame should fall on him for having neglected his wife and perhaps also his children.

The girl seems to have been born in an asphyctic stage. She remained "blue" for several days, had difficulty in breathing and could not drink. She did not seem to be fully conscious. She was breastfed for $2\frac{1}{2}$ years, learned to walk at 3 and to talk at 4-5. Presumably it was the father's impatience to see her develop as quickly as the elder children, which subjected her to the operation against "tied tongue". Already at the age of 6 she was sent to an English school. She had mechanically picked up some numbers and nursery rhymes, which she rattled down without any idea of the meaning.

When, at the age of 3, Nirmala had to face the birth of a younger sister, she continued to cling to her mother and showed intense jealousy against the intruder.

By the time we saw the child, it was not only the father's ambition that had driven her ahead against all her obvious infantile tendencies, but she herself had got into the habit of comparing herself with her siblings and aspiring to equal at least the younger sister, who in certain respects had got ahead of her. With this strain and all the teasing she got for her efforts, it is no wonder that she developed aggressive behaviour, tendencies to gain attention by lies and phantastic tales and that, on the other hand, she had to express her regressive needs by strange food habits, urinary incontinence and clinging to her mother.

One might perhaps have classified this girl as a case of neurotic development on the basis of brain-damage. What decided us to list her in this group was, apart from the regressive features, the father's report about her talking to herself at night and the way she dealt with the toys in the play-room. She was not capable of any organized activity. In a capricious way, she piled up the blocks at random. She made no distinction between wheels and top of railway trucks, but would

move them about in any position or even use them as building elements. She refused to perform any tests or then used the material absolutely at random, according to her fancy. On the blackboard, she drew a few spiral scrawls, and on a paper only an open circle.

As the father, even after we had gained our initial impression of his wife, seemed to be determined to keep her in the background, we had to try to work through him, though granting support to the mother might have been the more expedient procedure. His autistic inability to listen or to accept any advice, and his reluctance to face any psychological aspects, rendered this task rather difficult. The only way in which we were able to interest him and to create some understanding, was to talk quite casually, in an absolutely impersonal manner, and without any reference to his own situation, as one academic worker would discuss a matter of common professional interest with one of his colleagues, about the consequences of India's social transformation on family life and the upbringing of children. This had to be done by the psychiatrist, as a talk with the social worker was below his dignity ! Even so, he gave up coming after less than 2 weeks, and we do not know, how the child developed further.

This case, in contrast to many other, children in the group, was not characterized by mutism, nor even by "private language" or a merely automatic use of speech. The way, however, in which the little girl used her ability to talk for making up stories that should rouse concern and sympathy, without concern for reality, also betrays autistic tendencies. Finer shading of such autistic use of speech can be discovered in many situations, even amongst so-called "normal" people. One of our adult patients, a university-lecturer, through his psychotherapeutic interviews, gradually came to the insight that all his elegant and fluent lecturing had had the sole purpose of boosting his self-esteem and that he had never yet paused to think, whether his students got any benefit out of it ! Many of the contortions and distortions of certain types of modern writing, also give one the impression that the poet was merely out to prove to himself that he could perform certain tricks with words, but that he cared very little, whether anyone would "get anything out of it" !.

Not only the figures for psychiatric morbidity amongst family-members, in particular the parents, but also sibling mortality (Table IX), with 43.7 per cent of families and 19.0 per cent of the children, is unusually high for the group of infantile psychosis. Again one may ask, whether the fact that, in the same family, some children cannot survive the period of early infancy, while others grow out of it emotionally crippled, indicates a constitutional lack of vitality transmitted by the parents or rather an environment so poor in healthy emotional stimuli and maternal warmth and shelter, that a tender, helpless child can find no safe place in it. The fact that the figure for families in whom one or more siblings died in infancy or childhood is considerably higher amongst the children with signs of organic brain-damage than amongst those without neurological anomalies, at a rate of 62.5 per cent : 33.3 per cent, would rather tempt

one to assume the former possibility. It is interesting to note that, in 5 out of the 8 families, sibling mortality is associated with "psychiatric morbidity" in the mother. This, of course, does in no way help to solve our problem of biological heredity versus environmental influence. It may merely show, how closely constitutional, biological and even grossly physical factors may be interwoven with subtle psychological phenomena. Most of the children whose siblings had died have already been presented: there is therefore no need for further examples.

(10) *Number of Siblings and Position in Siblings-Row.*—Graph VI, illustrating the number of children in the families of our patients, shows, in the group of infantile psychosis, a pyramid somewhat similar to that for the infantile children, but with an extension towards the side of larger families, up to a number of 7 children born or 6 surviving. The most frequent number of surviving children is 2 per family. As most of the patients in this group are fairly young, one may expect that some of the families had not yet reached their definite size yet.

Again, as in the previous group, the relatively high proportion of families with less than 4 children, renders the figure for "possible special positions" (Table XI) very high, particularly if only the surviving children are considered. Though 68.7 per cent of the children actually occupied "special positions" amongst the surviving siblings, this figure still remains by 9.7 per cent behind the possible maximum.

No single position listed in Table X, not even eldest and only surviving children taken together, exceed the rate which would indicate equal risks of falling ill for all positions. One position, however, which from Table X is not evident, claims 50 per cent of all Indian children : that of the only son, either absolutely or in a family of girls. The value of this observation as indicating a psychogenic factor in this unique position, is possibly enhanced by the fact that 6 of these 8 cases occur in the sub-group in which no signs of brain-damage were noted, bringing the percentage up to 66.6 per cent, while amongst the organically affected children (including the Nepali boy), it only amounts to 25 per cent. Youngest children are also less frequent in the group with brain-damage (12.5 per cent : 44.4 per cent), while eldest children, either absolutely or of their sex, exceed the proportion amongst these without neurological signs at a rate of 50 per cent : 33.3 per cent.

In the examples quoted, the fate of some of these only sons has already been shown : Ravindra (115), not only the only son, but the only child in this second marriage; Sitaram (111), the younger of two children ; Prahlad (117) also a youngest and only boy, but with 3 surviving sisters ; Sajjan (110) and Virendra (118) with only one younger sister each ; all belonging to the sub-group without signs of organic brain-damage. The cases of Prahlad (117) and Virendra (118) have shown us that the position of the only son need not automatically be linked with a pampering and overanxious attitude of the parents. Both these boys were far more victims of neglect. In general, however, an only son in an Indian family risks to see a great burden of responsibility ahead,

while excessive pampering or overanxious restraint may do little to prepare him for his future tasks. In many ways, the life ahead does not really belong to him, but to the family, who regard the only son as an investment for all their hope, pride and ambition and also for security in old age. One of our older adolescent patients, who was the eldest, though not the only son, expressed this consciousness of not having a life of his own, but having to dedicate himself to higher interests, in the rather sarcastic remark : "I am not only the property of my family, but even the property of the Nation". This sense of being claimed, "used" for the purpose of others rather than being given a chance of unfolding one's own possibilities, and which can be implicitly felt in the parents' attitude by a child even at earliest age, is again very apt to provoke the autistic defence of "keeping oneself to oneself". The pampering, on the other hand, may foster expansive tendencies of experiencing oneself as limitless, as no refusal, frustration or resistance ever sets a boundary to the child's self-assertion. In the case of Ravindra (115), we have seen, how this autistic idea that the whole world was only a mirror for his own moods and desires, developed into regular manifold delusions at the age of puberty. Unlike the young patient just quoted, who saw himself as "the property of the Nation", this only child of a rich and respected father wanted to be called "The Father of the Nation", though not in the least willing to take upon him any of the responsibilities and moral obligations associated with deserving this title. He suggested that by "slipping inside a photograph of Gandhiji" he could become his successor in the love and esteem of the people !

As all the cases of only sons given up to now are from the sub-group without neurological signs, it may be instructive to add one case of a child with signs of brain-damage :

- (120) *Rakesh* came with his father and a family-friend from a town of Eastern U.P. His father a Brahmin, was a clerk with High School education. He suffered from asthma, probably on a psychosomatic basis, and had very little concern for his children. His wife, though described as talkative and sharp tempered, seemed to attend to their needs more carefully. With regard to this only boy, born after 4 daughters and followed by another girl, she displayed an overanxious, pampering attitude. Recently, however, both she and her husband had come to the point of losing patience with the little tyrant. At the age of 5, the boy would hardly ever use speech, but by his gestures, and particularly by his violent temper-tantrums, he could get all his wishes fulfilled. The father showed his exasperation during the consultation by shouting at the boy and prodding him roughly, as one would do with cattle. In presence of the accompanying neighbour, a calm, kind man, the boy could behave in a far more disciplined and docile manner. His siblings and the children of the neighbourhood avoided or teased him, calling him "pāgal". According to the father, the boy had been breastfed for 4 years. He started walking at the age of 2. He no doubt had some notion of speech ; but he would mostly talk in his own private language, occasionally mixing it with a few conventional words. When it suited him,

e.g. in order to have some need attended to, he could occasionally clearly pronounce a full sentence.

In the play-room, he liked to make noise with any suitable article. He did not use the blocks for building, but only arranged them in different fashions, once according to colour. On the blackboard, using right and left hand indiscriminately, he performed some big movements, aspiring to reach beyond the limits of the writing surface, and then drew some small circles. When the psychiatrist suggested that they might be potatoes, he repeated the word "alu". Finally he put the chalk into his pocket. When he was prevented from this act of hoarding, he went into the fit of temper described earlier : tearing open his shirt and flapping the front parts like wings, going on automatically with his crying and howling, long after he had forgotten the cause for this outburst. According to the father, the fit witnessed by us was very mild compared with the aggression and destruction he would go into at home.

Physically, the small and lean boy presented some asymmetry of the reflexes. The occipito-parietal region of his skull was bulging out in a strange manner, and the ears were abnormally shaped. We also noted excessive salivation.

An example of an eldest surviving daughter has been given in Ranjana's case-history (116). The fact that the mother devoted her time to studies rather than to the children, may however have counted more in her abnormal development than this special position.

- (121) One other girl, *Meena*, is not only the eldest daughter, but also the first-born child in the family, and at the same time an example for sibling-rivalry.

The father, a clerk from a Kshatriya family, described himself as good-natured and patient, but admitted that he did not take much interest in the family. The mother, in her harsh, short-tempered and domineering behaviour, betrayed an emotional immaturity which we had to characterize as neurotic. *Meena* was born one year after marriage, without complications of delivery or pregnancy. She only suffered from slight fevers occasionally. Unfortunately, the short contact with the parents did not allow us to gather a complete history of the child's early infancy. We do not even know, whether and how long she was breastfed : at any rate, it cannot have been longer than 2 years, as after that period a second girl was born.

Up to the age of 2, *Meena* showed no signs of "recognizing" her parents, a description that might fit early autism. She started talking a few syllables before the age of 2, but by the time she was 4, had not learned to speak properly. She also was still unsteady on her legs, though she had made her first steps at the age of 2. She could not announce her toilet needs yet and was greedy in taking her food.

At times she would go into fits of anger, screaming and throwing about things. She still sucked her fingers and occasionally would bite the mother.

On physical examination, we found a flat-backed skull, asymmetrical facial innervation, deformed feet and pathological reflexes in the right leg. The girl showed a definite tendency to use her left hand more, as the right side was slightly spastic.

In the play-room, she hardly knew what to do with toys. She liked to listen to the sound of a bell, but would not handle it herself. When she heard the music of a band passing in the street, she performed some dancing movements. Whenever any new object was shown to her, she screamed anxiously and clung tightly to her father.

The fact that the father, in spite of his lack of interest in the family, was a more positive figure than the irritable mother, who furthermore had "deserted" her for the younger sister, was reflected in the child's preference for the male doctor at our Center. She obviously resented the younger sister, whom she completely ignored. As often as possible, she would cling to one of the parents, preferably to the father. When put down on the ground, she would trip about with small steps for a while, but soon try to reach one of the parents again.

Probably brain-damaged already before birth, this child seems to have developed according to an autistic pattern in earliest infancy. The arrival of a younger sister may have deprived her of whatever motherly care she got. Our information about the mother's attitude is, however, too scarce to draw any such conclusions about the interaction of the various factors.

In the position of the youngest child, we have already seen Sitaram (111), who was breastfed for 4 years, Meera (114), to whom the deserted, elderly mother was clinging as her last refuge, and Prahlad (117), who in spite of his being the only son, was less important to his mother than her studies. Two more youngest children will be presented in some other context.

Sibling rivalry is a factor which seems to have played a role in at least 8 of the 17 children who developed psychotic symptoms. We have seen signs of it in Meena, just quoted (121), also in the other eldest daughter: Ranjana (116) and in Nirmala (119). None of these little girls was in the particularly exposed situation of a second daughter immediately followed by a boy. But, being very delicate, all 3 brain-damaged, they probably would have needed the mother's special attention longer than the birth of the next child allowed it. Also, the more vigorous constitution of the siblings, both elder and younger, seemed to be a threat, on the other hand a challenge to rival them, which went beyond their poor capacities for holding a place in this world by the normal means of human communication. It looked, as if the autistic shell had to save them from being "crowded out" or from indiscriminate merging.

This threat of being "squashed" by more robust siblings, was beautifully illustrated in a drawing by a delicate little American boy with infantile features, whom we have counted amongst the neurotic children. When asked to draw his family, he gave everyone full figures with round faces. Himself, however, he only represented as something like a moon-sickle with eyes and a nose and no body, squeezed into the narrow space between the elder brother and a 2 years younger sister, who was already "catching up with him". Apparently mixing up the two similarly sounding words for "mouth" and "mouse", he explained that his face had no mouth, because the younger sister had chased it away and, changing it into a "mouse", he drew the little creature below the feet of the elder brother ! This boy, who enjoyed a fair amount of maternal warmth and toleration for this infantile "backwardness", could bear the "crushing" without resorting to the protection of an autistic shell. One wonders, however, whether the banishing of the "mouth", chased away by the more resolute younger sister and trodden on by the brother, may not symbolically indicate a possible refuge into mutism, all the more, as at the age of 7 his speech was still indistinct and a target for teasing by his school-fellows.

Amongst the boys in our group, sibling rivalry played a role in Rajendra (113) and Prakash (112), the Nepali boy. Another fairly typical case is the following :

- (122) *Anup* was the son of a Kshatriya businessman. The father was described as short-tempered. The mother, thin and suffering from chronic digestive trouble, seems to have been married at a very young age and gave birth to her first daughter, before she was 16 years old. A next child, a son, was born 5 years later. After an even longer gap of 8 years, a second daughter followed. When, 2 years later, another pregnancy occurred, this was entirely unwanted. As the mother told us, she "had to accept God's will", but was sick all during the pregnancy and even after. Though the child, our patient, was born considerably after what was supposed to be the term for delivery, he only weighed 2 lbs. He was breastfed up to the age of 9 months and took milk from a bottle up to the age of 3.

Though the boy originally had been unwanted, his weakness made everyone pamper him. Later, he began to develop violent temper tantrums, so that, in order to avoid them, the whole family gave in to his wishes. Though he had already been stubborn, irritable and destructive since infancy, the birth of a younger brother turned him even more into a little tyrant. As this last pregnancy again was unwanted and resented by the mother, she reduced her concern for the patient already before the birth of the next child and even more so, when the little maternal interest left in her had to be turned to the new baby.

Anup, on the other hand, still insisted on his place with the mother by tenacious clinging and by regression into quite babyish behaviour. At the age of 4½ years, 4 months after the birth of the little brother, he cried for hours, when overcome by one of his fits of temper. He slept little and had no appetite. When together

with other children, he would fight with them or tease them. He passed stool anywhere and was observed to masturbate. He also frequently bit his nails. He had only learned to talk a few words.

The thin, asthenic boy presented various dysplastic signs ; an abnormal curve of the spine, asymmetry of the face, a squint, deformed legs and oddly prominent ears. Neurological examination showed no deviations. He walked with strange long steps, absorbed in himself, hardly ever speaking.

During the first consultation, he could not be induced to take any interest in toys. He clung frantically to the mother. One got the impression that the physical connection with her represented his only tie with reality. When it was taken away, the whole world seemed to crumble. He is the boy who produced the very impressive temper-tantrum described earlier : "looking like an ugly little dwarf completely possessed by rage". The only way to calm him was to deposit him in his mother's lap. Even there, as long as the mother did not explicitly turn her attention to him, while she was talking to doctor and social worker, he continued his enraged shouting, kicking and screaming.

In this boy, whom we saw 3 times, appropriate medication and advice to the parents were followed by an improvement, which the parents estimated at "12 annas in a rupee". We ourselves could state, during a visit about 4 months after start of treatment, that he was more accessible, less exclusively attached to the mother and capable of taking an interest in toys. He was, however, still observed to masturbate frequently and continued to pass urine in his bed at night.

Again, this boy, so immature at birth, probably needed a quite particular degree of maternal attention. The postnatal pampering could not quite compensate for the mother's original protest against this 4th child. When even this superficial sign of attention was taken away by the birth of the younger brother, the boy so-to-speak lost his world completely.

(11) *Age of the Mother at Birth of the Child* (Table XII).—The percentage of mothers aged below 20, with 13·3 per cent, is considerably below the average for all Indian children in our material, and the percentage of 6·6 per cent for "old mothers", representing only one case, fairly closely corresponds to the average. This "old mother", as we have seen, clung to her youngest daughter Meera (114) after she had lost her security by separating from the household dominated by her co-wife.

A young mother, aged 16 at birth of the child, was that of Sajjan (110). The theory that very young mothers are more likely to give birth to deformed and brain-damaged children, seems to be confirmed by the second case :

(123) *Lallu*, son of a Kshatriya businessman in a small country-town of U.P., was born, when his mother was aged 16, the father 20. Before that, however, the mother

had already given birth to a first son. This child had a severe deformation of the brain (one part of it, together with the wrappers, exposed in a kind of tumor at the back of the neck) and died after 3 days. Lallu was delivered without any complications, and no signs of any physical handicap were noted by the parents.

When we examined him at the age of 4, however, we discovered a slight irregularity of the coronary suture, indicating a deficiency in the joining of the skull bones and a "spina bifida occulta" (incomplete joining of the bones of the lower spine round the end cone of the medulla), *i.e.*, discrete signs of a Status dysraphicus, as the first child had presented it in much grosser form. The boy also had a slight squint and neurological examination revealed asymmetry of reflexes and tonus with a tendency to spasticity on the right. The right arm swang less during walking, and in play he often used the left hand. Both hands at times performed discrete athetoid movements, which seemed to be of organic rather than of psychogenic origin. Some falls in infancy and typhoid at 3 might have accounted for some of the neurological symptoms ; but they were far more likely to be signs of a malformation of the central nervous system.

A third child, a girl, born 2 years after Lallu, was well developed and could talk more at 3 than her brother at 5.

According to the family, the boy had developed fairly normally up to the age of 3. The only sign of disturbance they noted, was that the further development of speech got slowed down, when, during the next pregnancy, *i.e.* when the boy was aged 1½-2 years, the mother stopped breastfeeding. His regressive tendencies increased even more after the birth of the sister. When he first saw her being breastfed, he wanted to push her off the mother's lap and to resume his old place at the mother's breasts. Being still pampered by the whole family, he could easily dispense with speech, as by mere gestures he could command anything he wanted.

When the boy was brought to us at the age of 5, on advice of the family doctor, the parents were not only concerned about his reluctance to use speech, but also about his stubborn, self-willed behaviour, which often resulted in temper tantrums. He was restless, quarrelsome and destructive and only got little sleep at night. He never asked for food and at times ran away from home.

The delicate little boy, with mischievous, pretty features, is one of the children who showed much more tendency to withdrawal than to clinging of any kind. During 4 interviews, distributed over 3 months, we made the following observations :

While during the first visit he was very lively and mischievous, he seemed to be more depressed and anxious on later occasions. During the first 2 interviews,

he showed decided preference for any small, closed-in space. He discovered a refuge of this kind at the bottom of a flight of stairs ; but even more than that, he liked the narrow space between the window and the mosquito-screen, both reaching down to the floor, in the doctor's office. This small nook was just big enough for him to sit down in. He showed even more signs of contentment, when the windows were closed and the curtains drawn round this little "house". One could observe, how he moved his lips, as if to say something ; but he would not speak aloud. When the psychiatrist approached him from outside his "cage", pushing in a finger or a toy, he responded with a quite friendly smile. But it was obvious that he wanted to isolate himself in his glass-cage and only to keep up contact as far as it suited him. At times he would suddenly run out of his hiding-place with a joyful shout of "areh".

When he came for his third visit, he seemed to be in a mood of running about. But he did not object, when the by now fairly well known doctor caught him and lifted him up. Again he withdrew into his "glass-cage", this time taking a pad and coloured pencils with him. He covered several pages, mainly with odd scrawls in the form of circles covering and intersecting each other. When, on other occasions, he drew on the blackboard, —long, vertical lines —, he was very fastidious about washing his hands afterwards. Later, he consented to sit on the doctor's lap, watching her drawing some figures for him. A small baby was drawn, representing the little sister. When this page was torn, he laughed and kicked his legs with delight. At times he would leave this new found refuge on the psychiatrist's lap and explore the room, including the type-writer. But after such excursions, he would spontaneously settle in the doctor's lap again. Then he discovered a big cushion roll. Clinging to it and trying to suck it, he rolled about on the "takhat" with it very happily. While seeking physical closeness, he seemed to watch the doctor's breathing or even to listen to the beating of her heart. When a little nest was made for him with cushions in the corner of the "takhat", he snuggled up in it. At times, he now babbled in his baby-language or he even sang some tunes he had heard on the radio. He also seemed to take pleasure in copying what other people said, but showed little inclination to use language for any purpose of communication.

While, during this third visit, he definitely showed signs of wanting human closeness and perhaps communication on a very infantile level, the next and last interview showed him in a quite different mood : He ran about restlessly, once ejecting a jet of urine before him, while walking, obviously a very pleasurable performance! When he climbed up on the doctor's lap, he suddenly started scratching her face, joyfully laughing while doing so. In the waiting-room, where perhaps too many family-members, including the little sister, had assembled this time, he gave a demonstration of one of his temper-tantrums, in which he could hardly be controlled even by several men. He tried to attack the baby-sister by beating and pushing her. The father seemed too lenient and helpless to control the boy.

The mother obviously was very immature and, as far as we could make out from her interview with the social worker, intellectually very limited, if not outright mentally deficient.

This case provokes an interesting reflection : We have reported that both, the patient himself and the elder brother who died, presented what is described as "Status dysraphicus". By this Greek term ("raphe", suture, line of joining), one means a certain group of malformations originating from an incomplete closure of the central nervous system and its firm coverings. In the early phases of embryonal life, the material for the nervous system is spread out openly on the surface of the embryonal disc ; only gradually it is "folded in" and enclosed in boney structures and various membranes. This process, however, can be disturbed at various stages, some of them obvious on outward inspection, others only on examination of the brain after death. Was this lack of "insulation" of the nervous system paralleled in this boy by a similar lack of an individual "enclosure" in a less grossly physical sense ? Did his tendency to withdraw into a small, closed space, from which he could view the world through a glass-screen, attempt to make up for the deficient "membrane" of his ego-boundaries ? Some authors have found an uncommonly high percentage of discrete "dysraphic states" amongst schizophrenic patients. One is tempted to risk a rather pointed formulation : "What is not folded in, cannot unfold" or : "only what is properly enveloped, can also develop."

The fact that definite signs of withdrawal with little or no attempt at clinging were only found in the group of organically damaged children (See Table 22), and there in 37.5 per cent, while partial withdrawal, alternating with clinging, only characterized 22.2 per cent of the remaining children, might indicate that lack of physiological insulation through an intact nervous system disposes to seeking psychological isolation. The organic brain-damage is the only factor which all the 3 cases of predominant withdrawal have in common. Even in the 2 cases in the sub-group of children without obvious brain-damage the columns either for organic or dysplastic signs are filled with a question mark. The one boy (117) had doubtful plantar reflexes ; the girl (114) slightly dysplastic features. Of the two boys in whom we had no definite signs of either withdrawal or clinging, the one was asphyctic after a prolonged and difficult delivery ; the other one is the deaf boy.

Though our small material may not allow any conclusion, this observation of the association between lack of insulation by a defective nervous system or its incompletely closed wrappers and, on the other hand, the need for autistic isolation, may throw some light on the significance of our "sliding-scale" in demonstrating the varying role of different organic and psychogenic factors in favouring an autistic development. It may not be by chance that the case of Lallu, (123), which led us to these reflections, is placed at the extreme "organic" end of the scale !

(12) *Complications of Pregnancy and Delivery* (Table XIII).— As organic brain-damage, without much evidence of possible postnatal injury, is relatively frequent in

the group of psychotic children, one is rather surprised to find low percentages for disturbed pregnancies (6.2 per cent) and complicated deliveries (12.5 per cent). If in Table 22 these figures are somewhat higher, this is because, amongst disturbances of pregnancy, we have not only included conditions that were a direct physical threat to the embryo, like imminent abortion or severe infectious illness of the mother, but also situations that tended to upset the mother's emotional equilibrium. These cases, however, are marked by a plus sign in brackets. The figure for complications of delivery includes a few cases in which delivery itself proceeded smoothly, but in which the child showed signs of asphyxia or particular immaturity after birth. Two of the children are supposed to have been born considerably after term, without, however, profiting from this extension of intrauterine life by a particularly vigorous development. One boy, even when born during the 11th month, was reported to have weighed only 2 lbs. (Anup, 122), while another one showed signs of asphyxia after a delivery delayed up to the end of the 10th month. We have no means of controlling these data and have to take the mothers' reports on good faith. An interesting "coincidence" may be that both these children who overstayed the normal period of intrauterine life, were unwanted ! Should one suppose that the mother's hostile and resentful attitude denied them healthy nurture already in the womb or may it be that the mothers found them less troublesome while still safely kept "inside", where they were being cared for automatically ?

Not only both these children, but the majority of cases in which pregnancy and delivery were complicated, are to be found in the sub-group without neurological signs of brain-damage. It is of course possible that the central nervous system may have suffered in regions in which damage or mere immaturity are not likely to produce any alteration in the particular functions accessible to neurological examination and yet may reduce the "insulation" provided by an intact brain.

(13) *The period of Breastfeeding* (Table XIV).—Except for 2 children, for whom information was not complete, we know the length of the period of breastfeeding in all cases of this group. 5 of the 16 Indian children, *i.e.* 31.2 per cent, were breastfed beyond the age of 2 years. Of these, we have already quoted Sitaram (111) and Rakesh (120), both only sons breastfed for 4 years, Nirmala (119) with 2½ years and Rajendra (113) with 3 years of breastfeeding. One further boy insisted on his right to the mother's milk even beyond the birth of the next sibling :

(124) *Somnath* was the 4th of 5 children of an overseer from the Baniya caste. The father was irritable and loose-tempered and therefore avoided dealing with the children. The mother cared well for them, but was rather too anxious about them. Two brothers and one sister elder than our patient were developing well, all attending classes beyond their age level. The 4th and the 5th child, *i.e.* our patient and his younger brother, were both unwanted children. The mother resented the pregnancy with Somnath and her mood was all the more depressed during it, as someone in her family died during that period. The delivery, delayed up to the end of the 10th month, was prolonged and complicated. The child did not

breathe immediately. When the next child, also a son, was born about $2\frac{1}{2}$ years later, Somnath refused to give up the mother's breast and therefore continued to receive her milk for another 3 months, until he was aged almost 3 years. He started walking at 2 and only spoke his first words at the age of $5\frac{1}{2}$. Again, attributing this retardation to a peripheral cause, the parents had the child operated for "tongue-tie". One can imagine that this operation (consisting in cutting through the skin-fold that links the posterior part of the tongue with the bottom of the oral cavity), which apparently was in fashion in many countries up to the beginning of this century and for which special gadgets still figure in older sets of surgical instruments, far from encouraging a retarded child to speak, is likely rather to set a new experience of shock and oral frustration !

Apart from occasional fevers, digestive upsets and some ear-trouble, the boy remained physically healthy. At the age of 6, however, he still hardly talked. He could understand everything and announce his wishes by gestures. He would, however, only ask for things that were in front of him and not for anything that could not be pointed to. If any wish was not fulfilled, he would cry and lie on the ground. When drinking, he made smacking noises. He was very particular about order and cleanliness.

Apart from some purulent discharge from the outward portions of the ear and rather loose limbs, examination revealed no signs of any physical damage. There was not enough time to explore the case more thoroughly. All we could find out was, that the mother had some guilt feelings about having resented the last 2 pregnancies and that these formed the basis for her overanxiousness about the patient.

This case again proves, what we have already pointed out earlier, that an unusually long period of breastfeeding need not be an indicator for a mother's true care for her child. Continuing lactation may merely be a matter of practical convenience, saving the time and trouble that would have to be spent on more elaborate methods and, as we have repeatedly seen, a very useful superficial demonstration of motherly devotion and a defence against more deeply seated negative attitudes. Not the fact of breastfeeding and its duration as such may be important in estimating a mother-child relationship, but the spirit of concern for the child's optimal development, which in an emotionally healthy mother is usually supported by an intuitive knowledge of what is best for the child at any stage of his growth.

Possibly prolonged breastfeeding may produce different effects not only according to the child's constitution, but also according to the environment for which he has to be brought up. The mother's milk, as we tried to show earlier, provides a type of nourishment which requires a minimum of breakdown and transformation to become the child's own body-substance. If a child, as this was the case in the old social order in India, was to spend his life predominantly within his own family, his own caste, his

own village or mohalla, *i.e.* in a setting which was strictly limited to people of his own kind and with similar ideas about what was wholesome and what was harmful, his ability, physical, mental and emotional, of absorbing and assimilating "foreign matter" were not likely to be severely taxed. His being brought up on "homeoplastic" food in every respect, therefore was a fit preparation for this limited existence. One may, however, be justified in assuming that, in a culture which expects the individual to step out of his childhood surroundings, to mix with all kinds of "foreign" elements and to assimilate influences often undreamt of by his parents or quite contrary to the traditional background, the process of learning to digest, to transform "foreign matter" into one's own, should set in already early in life and include the physical aspect of acquiring the ability to utilize food from various sources. Where, however, a child's ability to deal with the outside world is reduced by brain-damage, immaturity or some other weakness or handicap, prolonged breastfeeding, if offered by the mother judiciously and with real emotional warmth, and not with a view to her own convenience and satisfaction only, may be a saving factor which allows the child to store up energies for his difficult way through life.

In our group of psychotic children, apart from the considerable number of children who, for one reason or other, continued to receive their mother's milk for an unusually long time, we also have a few who were weaned rather too soon or too abruptly. In Ravindra's case (115), we have seen that the delicate, refined mother took chicken-pox as an excuse for stopping breastfeeding after 3 months. Another boy was weaned even earlier :

- (125) *Ranjan* was the younger of two sons of a Kayasth in a high position in Police Service. The father seemed to be fond of the child and intent on fulfilling all his wishes. The mother denied any particular clinging to the boy from her side ; but we had no chance of investigating her attitude more closely. The elder brother, already 12, when Ranjan was brought at 5½, was good in his studies, but showed no interest in games and other physical activities.

During her pregnancy with our patient, the mother suffered from anaemia. It was probably for this reason that she gave up breastfeeding already one month after the delivery, which had passed normally at full term.

At the age of 3 months, the boy suffered from whooping cough and at 2 years he was suspect of diphtheria, both illnesses that can mean an experience of "oral frustration". He started sitting at the age of 8 months, standing at 16 months, walking at 20 months. He spoke his first words at the age of 2 years and was able to combine sentences at the age of 3. His toilet habits were not perfect yet when we saw him at 5½.

The parents were worried about his "mental backwardness", his tendency to withdraw, his lack of interest in toys and his persistence in certain fixed habits.

He was very reluctant to face any change, for instance in the mother's dress, and could be quite obstinate about keeping things in their usual order. He could sit for long periods just waving a branch or gazing at some running water or some birds. He frequently sucked his thumbs. At night he was restless and at times got out of his bed. Generally anxious, he had developed a particular fear of thunder. According to the parents, his strange behaviour had first been noted at the age of $1\frac{1}{2}$, when, during some fever, he kept banging his head on the ground and, at the same time, was restless in his sleep. We cannot quite exclude that this fever may have been an attack of encephalitis. The left leg showed some pathological reflex responses ; but the skull was asymmetrically shaped, so that this neurological disturbance might just as well have been due to some congenital damage.

The boy looked younger than his age. He was restless, refused to obey any orders and showed no interest in toys. He consented, however, to look at a picture book and could name figures correctly and grasp the situations represented.

Except for a slightly pampering attitude, particularly on the part of the father, no gross disturbance in the family relationship could be noted. It looked, as if the damaged nervous system, perhaps further weakened by infections, had been unable to deal with a world which denied him the continuity of nourishment from the mother so early.

In another case, the period of breastfeeding, with $1\frac{1}{2}$ years, was quite considerable, but seems to have been ended all too abruptly, without any smooth transition.

- (126) *Sushil* is the case at the "psychogenic" extreme of our sliding-scale (Table 22). Apart from pneumonia at the age of 10 months, he seems to have been exposed to no physical damage of any kind, neither hereditary, nor intrauterine, nor postnatal. All the same, his symptomatology was made up of 9 of the features which we regarded as typical for this group.

Sushil's father, a businessman of the Baniya caste, with High School education, was a simple, mild and sociable man. The mother had only had primary education. She was described as hardworking and quick-tempered. She impressed us as rather immature. In our presence, she dealt with the patient by means of threats or false promises. She obviously was only out to satisfy him for the moment, so as to get her own "peace", but had no concern and understanding for any long-range necessities.

One sister, $2\frac{1}{2}$ years older than Sushil, seemed to be developing without any difficulty.

The boy was born without complications. At the age of 1 month, he was once observed to cry almost continuously for several days ; but no particular cause was found.

When he was 18 months old, breastfeeding was stopped abruptly, and the boy was left with his grandmother, as the mother had to go to hospital. From the few hints we got, we strongly suspected that at that time, by an attempt at criminal abortion, she had injured her genitals. An operation had to be performed, which rendered her incapable of having any further children. This of course meant that she concentrated her attentions all the more anxiously on our patient. He, however, when the mother came back from hospital after 6 to 8 weeks, refused to go to her. It took 4 to 5 months until he approached her again ; then, the first thing he did, was to try to suck her breasts, obviously resuming the relationship at the point where it had been broken off. Shortly before we saw the boy, *i.e.* at the age of about $3\frac{1}{2}$, he was again separated from the mother rather suddenly, when she went to nurse the sick child of relatives. Observing the family's behaviour with the boy, we could well imagine that, during that period, day after day, he would be consoled with the empty promise that mother would "come back tomorrow". When she finally returned, he again refused and ignored her for some time.

The whole description the parents gave of his behaviour at the age of 4, pointed to the fact that he was only interested in the world as far as it served to fulfil his immediate wishes. The only syllables he spoke were "ma" for mother, "pa" for father and "kha" for food. Usually he indicated his needs by gestures. If any of his wishes were not fulfilled, he would lie down on the ground and make himself stiff. During meals, he grabbed his food. When together with other children, he would occasionally give a toy to a younger one, but claim everything from those who were older than himself. He was very careful about his belongings. He never allowed the mother to give away his worn-out clothes and objected strongly to seeing anyone else wearing them. We were able to observe quite significant features in his behaviour, and at the same time in the mother's way of dealing with him during the one consultation for which he was brought at the age of 4. The boy was rather thin, but otherwise developed according to his age and quite agile. He only spoke a few syllables like "ammi" and "pa", but was very skilful in expressing his wishes by gestures, to which the mother almost automatically responded.

In the play-room, he first demonstrated one of his temper-tantrums. The mother, in order to calm him, first threatened to lock him up or to beat him and, when this had no success, promised to give him money or sweets. While waiting for his consultation, he had actually been playing with some coins, but finally threw them away carelessly. We tried to explain to the mother that, by her threats and false promises, she would only make the child more insecure and encourage him in his distrust of the future and his clinging to a fixed order

of things. By sheer force of habit, however, already during the later parts of the interview, she fell into her usual methods of frightening threats and useless promises again.

Gradually, the boy showed some interest in the wooden blocks. He took his mother's handkerchief, spread it on the ground and started piling all the blocks onto it. In his greed, however, he put too many, so that he could not tie up his bundle. This made him angry and, by his language of gestures, he asked the mother to help him. It was obvious that the mother was used to give in to such requests and that she had never, in true "anticipating care", tried to encourage or teach the boy to do things for himself. When, even with her help, the bundle could not be tied up, she foolishly suggested that he should put the blocks back into the basket and take this home. At this point again we had to intervene to make the reality situation clear to both mother and child. The boy then emptied out the whole basket and sorted out the blocks. Still with a view to hoarding in the mother's handkerchief, whatever might find place, he discarded the biggest pillars which formed most of an obstruction. When given chalks, he first refused, then tried to pocket them.

In spite of his having been separated twice from his mother, and in spite of all the disappointments she must have given him through all her short-sighted promises, the child still clung to her. He would stand before her, holding out his arms, just like a small animal wanting to be picked up by the mother.

An ability to trust and to foresee the behaviour of people in one's surroundings, is a primary necessity, if a child is to learn to postpone the fulfilment of his wishes. Not only that, but a view of a future, a prospect into more than just the immediate "now", is the necessary dimension for development and growth. Even language seems to be connected with the ability of gaining a mental representation of things that are beyond the present, either in time or space. What is present, immediately before one, can be touched, grabbed or pushed away; the more differentiated effort of language is not necessary to name it. Where existence is limited to a fragmented succession of moments of "here and now", without the dimension of a past held in memory and a future as the realm of possibilities, development cannot be harmonious. Attempts at hoarding, at compulsively "keeping things as they are" may try to prolong and freeze these "moments of here and now", but they are a poor substitute for the living flow of a continuity of growth, of which the very elements are change and transformation.

(14) *Toilet Training.*—In 9 of the 17 psychotic children, disregard for the world of the others and narrow limitation to own immediate needs, was manifested in disturbances of toilet training. We have seen, in several cases, that these did not consist in a physical inability of establishing control over these functions, but in a quite wilful or at least deliberately careless voiding of excrements in places not meant

for this purpose. One may remember 4 year old Sitaram (111), who took pleasure in urinating into his plate during meals, and Lallu (123), who cheerfully walked through the corridor splashing his way with a jet of urine, also Ravindra (115), who, at the age of 10, tried out his therapist's patience by soiling her clothes with his urine is a quite controlled and premeditated act. While this same boy kept a meticulously compulsive order in his bathroom at home, he betrayed, after months of psychotherapy, an interest in eating his stool. Again a proof, how thinly compulsive habits often cover up the very opposite of what they aim to profess !

Excrements, as being "of one's own substance", have a quite particular value in the autistic and even more the outright schizophrenic person's world. It is a none too uncommon experience that a patient's first friendly gesture to his therapist consists in offering him some of his excrements, which usually he may try to eat himself. An observation of this kind, concerning an autistic girl of 5, is reported by B.M. Batliwala (32) in the only study on an Indian child of this type known to the author. After describing the girl's play with cooking utensils and her interest in throwing sand into the W.C., Miss Batliwala adds : "In one of the later sessions she had a bowel movement which she suggested the therapist to eat."

One may reasonably suppose that, at least in some cases, behaviour of this kind may be due to excessively early toilet training. To acquire regular and clean habits in this respect, is one of the first concessions the child has to make to the convenience of others, an irruption of "giving" into the infantile world of "taking" only !

Unfortunately, we know hardly anything about the timing and the methods which the mothers of our psychotic children used for achieving clean habits in them.

(15) *Early Neglect and Separation.*—Except for the Nepali boy (112), we have no evidence of gross maternal neglect, nor of separation during the first few months of life in any of the cases in this group. Several children, however, had been definitely unwanted ; so Anup (122), Ranjana (116), Somnath (124), Meera (114). But we have seen that, once these children were born, fairly good care was taken of them. 3 of them were breastfed for more than one year, one even for 3 years. The one most likely to have experienced neglect is Ranjana (116), whose mother was studying. But, as we have seen in other cases, the mother justified her scarce attention with the argument that "the child did not give much trouble" ; at the same time, however, the stereotype movements she was observed to perform, may already have been the result of lack of human contact. This girl, furthermore, was separated from the mother at the age of 3 years, when she went to the hospital accompanied by the father. As the latter, however, seemed to be more of a "mother figure", this rather late separation may have been of little consequence.

Sushil (126) just quoted, reacted to separation from his mother, which at the same time marked the end of breastfeeding, at the age of 18 months, in a typical manner :

not recognizing or ignoring her for several months after her return. Such behaviour on the part of a child, can initiate a vicious circle : The mother, resenting the child's withdrawal, may lose further interest in him or, on the other hand, force her attention on him in a manner that makes the child shrink back even more.

Though gross neglect may not have been the lot of any of the children in this group, more subtle and personal needs on which their possibilities of growth depended, were probably neglected in all of them in some way or other.

Attempts at abortion do not seem to have been made during the pregnancies with the children observed by us. Two mothers, however, interrupted subsequent pregnancies, after already having resented the birth of the children who became our patients.

(16) *Parental Attitudes* (Graphs VII and VIIa).—The various parental attitudes that appear to provoke or at least to favour autistic development in children with a certain disposition, have been discussed in the general paragraphs introducing this chapter, and demonstrated in detail in the individual case-histories. The one central fact that deserves notice, is that not a single one of the children in this group enjoyed total acceptance and normal concern from both parents. In the two cases of at least "one-sided" acceptance, it was the father who manifested this positive attitude.

The synoptic Table (Table 22) contains a column in which the parental attitudes have been noted. This Table allows to study the possibilities of specific combinations of any particular attitude with either other causing factors or with the resulting symptoms. As far as the author could make out herself, the only correlation that may be significant, is the greater frequency of neglecting attitudes, either by one parent only or by both, amongst the cases with organic brain-damage ; (62·5 per cent against 33·3 per cent in children without neurological symptoms) and a slightly higher rate of pampering and overanxious attitudes in the parents of children without demonstrable neurological signs. This might possibly mean that, for a child whose abilities to build up ego-boundaries are reduced by some organic brain-damage, a "too much" of parental concern may be less harmful than to be left in the vacuum of neglect and rejection, while a less handicapped child, who may have resources to overcome frustration and even to grow by it, is perhaps more likely to respond with an autistic defence, if overwhelmed by parental overconcern and anxiety. We have, however, seen that each case presents so intricate a mosaic of factors that play together in a unique way, that any generalisation of this kind might only obliterate what the detailed study of the individual history can bring to light more clearly.

One fact seems to be proved by our material : it is not only the emotionally cold, matter-of-fact attitude of the sophisticated intellectual parents that can force children into an autistic pattern, but any attitude by which the parents "use" the child for the satisfaction of their own ambition, pride and other emotional claims instead of giving

him both freedom and shelter for a development according to his own needs and possibilities.

(17) *Physical Defects* (Table XVI).—The frequency and role of organic defects of the central nervous system and of dysplastic signs has been noted in Table 22, in which the order is actually based on the presence of such signs. A physical defect not strictly falling into these 2 categories, was only present in the one deaf boy. The percentage for children with neurological signs of brain-damage, if we exclude the Nepali boy, amounts to 43·8 per cent, and is herewith highest amongst all “functional” groups. The figure for dysplastic signs, with 25 per cent, also exceeds that for the other functional groups.

Examples of particular cases presenting either brain-damage or dysplastic signs or both, can easily be picked out with the help of the synoptic Table 22.

While our material would not allow to regard infantile psychosis exclusively as a disorder due to a damaged or immature nervous system, as some authors maintain, it seems to suggest that lack of “insulation” through deficient functioning of the nervous system or through any other constitutional factor that is apt to reduce the ability to establish firm ego-boundaries, may dispose a child to an autistic development, even if he is not exposed to the severely traumatic environmental factors which some Western authors describe as typical.

(18) *Former Illnesses* (Table XVII).—Amongst former illnesses, the only ones that were reported with some frequency, were typhoid in 2 cases and various “fevers” including chicken-pox, whooping-cough and diphtheria. The latter two might be of special significance, as the symptoms (tendency to spastic cough and vomiting in whooping-cough and obstructive membranes in the throat in diphtheria) are apt to cause “oral frustration”. Dystrophic conditions of the type of rickets had left signs in 2 cases, while “liver trouble” seemed to have occurred in one case only. 3 children had sustained minor injuries. In 2 cases, the parents had attempted to “loosen the tongue” by subjecting the child to a probably unnecessary operation.

Altogether, the list of illnesses from which these children had suffered, is not very rich and, in most respects, remains behind the figures for the neurotic group, though, on the other hand, it exceeds the ones for the group of infantilism. Again one may ask, whether these children of a relatively low age had already profited from the better prophylactic facilities during recent years or whether, coming from well situated families, they enjoyed better care and fewer occasions for exposure to infection than children in other groups. Or may it be that, similar to adult schizophrenics, amongst whom many show an amazing immunity to physical illness, these children manage to seal themselves so hermetically against the outside world, or to express any weakness so completely in the emotional sphere, that diseases of the body cannot touch them?

(19) *Education*.—If we assume 6 years as the normal age for school-entry, 10 of the 17 children in this group could not be expected yet to have started on any course of formal education.

Of the 7 children aged above 6 years, 5 had been sent to school. 2 of them, Prahlad (117), aged 8, and Meera (114), aged 11, were "incapable of learning" and had to give up the venture.

Rajendra (113) also hardly profited when starting school at the age of $8\frac{1}{2}$; but he still continued to attend class, at least when he felt in a mood to do so.

Nirmala (119), at the age of 7, had only just been admitted at an English school. She was able to memorize numbers and nursery rhymes mechanically, but did not seem to understand much about their meaning. The parents were keen on continuing the experiment, and the girl herself showed a certain ambition to persist, as the younger sister threatened to catch up with her or even to overtake her.

Ravindra (115) had begun to attend an English school, when he was first examined at the age of 7. By the time he was aged 11 to 12, he had gone through the programme of the junior classes, though usually only "promoted", as his anxious mother wanted to spare him the tension of having to appear for any exams. As long as he continued in this junior section, in which boys and girls were taught together by female teachers, and where special exceptions were often made for him, he picked up quite a bit of knowledge. Due to his impulsive behaviour, his tendency to harass the teachers by indiscipline and rude remarks, and to his quarrels with fellow-pupils, he had to be excluded from class for short periods from time to time. Even then, thanks to his remarkable intelligence, he was able to keep up with the other children. When, at the age of 12, he was admitted at a boys' school, where less special regard was taken for him, he only stood the strain for a few months and then had to be kept at home and taught by a private tutor. Probably this reverse in his condition would have come in any case with the approach of puberty. One could, however, note, how any phase of special tension, *e.g.* when he was preparing for a test or taking particular pains to improve his performance in some subject, he had to seek increased outlet for aggression and infantile tendencies during his therapeutic sessions.

One boy, Ranjan (125), was sent to nursery-school at the age of $4\frac{1}{2}$. The teacher's report indicated that he could not obey orders, that he was only interested in painting and music and that most of the time he would insist on sitting on the swing.

For children as severely disturbed as the ones in this group, formal education in a normal setting presents many difficulties. Intelligence as such often is not impaired at all. What is lacking, is the willingness to put the powers of thinking to any common use. To acquire knowledge and to solve problems which have no obvious connection with one's immediate needs, presupposes a readiness to "give a place" in one's

attention and concern to the objects of study ; the autistic child, however, usually is only interested in "taking" a place in this world, to turn his interest to any object or person only as far as they can serve to cover his needs. If, for some reason, as for instance Ravindra (115), even an autistic child takes a certain pride in mastering some skill or knowledge, he may prefer fields in which there is scope for imagination and individual formulation, while he may fail in any subject in which the answer to any question can only be either completely right or wrong. This is for instance the case in science subjects, which are governed by a strict order that does not bear the superimposition of any personal fancy. On the other hand, compulsive tendencies and a preference for the abstract may determine particular proficiency in mathematics. According to Bosch, whose recent monograph we have already quoted earlier (8), the criterium for an autistic child's interest in some field of knowledge, would be the fact that it can be explored and pursued without engaging him too much in the conventions and concepts of the "common world".

Apart from the actual problems of learning and retaining, participation in a class taxes the poorly developed social sense of the autistic child. As he cannot realize and respect the needs of other people, he will not understand the necessity for sacrificing his own interests and impulses to a common order. Furthermore, the many stimuli in a crowded classroom may flood the relatively unsheltered nervous system in an intolerable way and cause additional strain and nervousness.

Children of this type, if they are fit for learning at all, should therefore be taught either privately or in special small classes by teachers trained in dealing with emotionally disturbed pupils.

(20) *Interests*.—For 7 of the children in this group, special interests were signalled : Two were fascinated by mechanical gadgets and vehicles ; 2 each liked good food and fine clothes ; 2 delighted in playing with water and mud, one in indiscriminate noise and 2 in music and dancing. One was described to like toys and 2 boys were interested in books. All these are more or less solitary pursuits, for which no partner or team is needed. Not a single child favoured motor activities or manual occupations.

(21) *Number of Visits and Possibilities of Treatment* (Graphs VIII and IX).—50 per cent of the Indian children or 52.9 per cent of the whole group, including the Nepali boy, were only seen for one consultation ; 3 children came twice and 2 each 3 and 4 times. Only one boy remained in psychotherapy over a prolonged period.

With these slight chances of helping, either through drugs or through advice to the parents or even through direct psychotherapeutic contact with the child, some degree of improvement was reported in only 4 cases.

We have mentioned earlier that, quite generally, parents seemed to be more reluctant to cooperate actively and persistently in any treatment programme, when the

child's disorder was a reflection of their own emotional problems or immaturity. As in this group all parents showed attitudes that were harmful in some way and as, very often, the child's trouble was a direct replica of some distorted emotional need in at least one of the parents, one could neither expect much understanding nor willingness to cooperate in treatment.

Some Western authors mention that the parents of autistic children often are singularly incapable of seeing and appreciating anyone else's point of view and of accepting advice. We have given examples of such rigid attitudes in the histories presented. Even in the one case in which the parents themselves insisted on the boy's prolonged treatment, the mother remained evasive and quite reluctant to talk about her problems, even after long acquaintance with doctor and social worker. She made it quite clear that she was only coming to report about the patient and to learn something about his "case" from us and that she was in no way inclined to draw away the curtain of prestige from the private life of the family. Under these circumstances, even the time and patience invested in dozens of sessions with the boy, did not bring their optimum fruit, but only resulted in temporary phases of improvement and finally, after treatment had been stopped, an obvious downhill move at the approach of puberty.

The modern tranquilizers can often help to calm overexcited, anxious and tense children, while other drugs can stimulate the withdrawn ones and facilitate contact with reality. The essential need of most children, however, is a change of attitude and emotional growth on the part of the parents and, until this can be achieved, the steady understanding concern of the therapist, who allows them to be and become what they really are and not just the distorted product of their parents' needs and ambitions. In severe cases, removal from the harmful home atmosphere and treatment at a residential institution may be more effective than psychotherapy on an out-patient basis.

9. *Adolescent Psychosis.*

(a) *Definition and Differential Diagnosis.*

The last group we have to present, that which we have named "adolescent psychosis", takes a kind of intermediate position between children and adults. According to age, the 11 cases still fit into our material of children up to the age of 16. The symptomatology of their psychotic disturbances, however, comes quite close to adult patterns of schizophrenia. In trying to illustrate the various stressful situations that lead to breakdown in adolescence, it might have been more expedient to group together all young people from puberty age up to the relatively adult age of 20. In order to keep to the task we have set ourselves, *i.e.* to give an account of all patients up to the age of 16, we shall respect the age limit.

It may, however, interest to have at least some idea of the number of psychotic patients in later adolescences. While the small group under discussion, containing

children aged 13 to 16 years, is made up of 11 cases plus 2 combinations with oligophrenia, we find, for the 4 years between the terminated 16th and 20th year, 61 psychotic adolescents, the majority of them (44) between 18 and 20. These 61 cases constitute 12.2 per cent of all adults of the corresponding categories.

While, for the group of infantile psychosis, we had deliberately chosen a rather wide designation, avoiding the terms "autistic" and "schizophrenic", there is no reason, except the wish to balance the names of the two groups, why this group of psychotic adolescents should not be characterized as "schizophrenic". All the cases can in fact fairly easily be accommodated within one of the customary sub-divisions of schizophrenia. Manic depressive psychoses were not found at so early an age; whatever organic cases may have had a psychotic component, have no place in the functional section.

As this is the last diagnostic group to be discussed, it has already found its characterisation through the definitions of the previous groups. The disorders summed up in it, differ from the congenital-organic groups by their postnatal start and the lack or merely accessory character of any signs of brain-damage. From the groups of "infantilism" and "infantile psychosis", it is set off by age. The distinction between adolescent schizophrenia and neurotic manifestations is not always quite easy to make. One may remember that we marked several young neurotics as "borderline cases", for instance when temporary signs of hallucination, depersonalisation, excitement and withdrawal were observed, but, on the whole, contact with reality still seemed to be kept up. One of these cases (Fatima, 90) was observed to have changed more definitely to psychotic patterns, when seen 2 years after the first consultation, without any appropriate treatment in the meantime. As we have mentioned earlier, the fundamental distinction between what one would still call neurosis and what would deserve the name of schizophrenic psychosis, may lie less in any particular symptom or set of symptoms, but in a basic attitude of wanting to preserve or, on the contrary, to avoid and ignore human communication and the common world in which experiences can be objectively verified and shared. This is something which the observer often can sense more intuitively than by any rational compilation of well-defined symptoms.

Seven of the pure cases and the 2 combined ones correspond most closely to what one calls "hebephrenia", a term (from Greek "hebe", youth) which actually means "the mental illness of the young". This does not only imply that this form of schizophrenia is the one most likely to take its start at an early age, but also that the symptoms, in their most typical expression, remind one of the slightly foolish, often uninhibited and giggling or then awkward or manneristic behaviour of young people during puberty age. The hebephrenic somehow lacks proportion and harmony in every respect. Often even the physical appearance and the movements are marked by a loss of grace and rhythm. Certain hebephrenics, particularly the younger ones, go through phases that closely resemble mania, *i.e.* one of the phases of manic-depressive or cyclic psychosis. While in the cycloid patient, however, his mood, his thought and his acting are all of one piece and often still so close to reality that they can be quite infectious or at least

provoke an emotional resonance in the observer, the manifold raptures of the hebephrenic often have something incongruous and bizarre about them ; they impress one as foolish boasting or clownish distortions and leave one unaffected or even inspire an uncanny sense of horror. Often the contents of verbal formulations lack coherence or at least contrast with the emotional tone or with an accompanying gesture, thus betraying the inward disintegration. Lack of concentration, inability "to control the mind", are often amongst the first symptoms experienced. In our young hebephrenic patients, the manifold element was often predominant. Some of them seemed to have burst all boundaries and to revel in illusions of omnipotence and omniscience. The famous "Thou art all that" of old Indian philosophy seemed to have come true for them in one magic flash, but of course without any depth and without any of the firmness and contained power that only comes from long discipline. They had not taken the world into themselves and made it their own by really digesting and assimilating it, but they imagined that they could cover it by simply spilling themselves all over it without any restraint.

The other sub-group of schizophrenia, represented by 4 of the young patients, is catatonia, either in its excited or its stiff withdrawn form or in a mixture of the two. Catatonia originally means "tension disease" (from Greek "katateino", to stretch, span, distend). While in the hebephrenic, as we just tried to describe, one often feels that all boundaries have been discarded and that no attempt is made to keep anything together, the catatonic, in his stiff, withdrawn phases, seems to creep completely into a thick shell, which protects him from contact. In some cases, the shell appears to have the purpose of keeping some influence out ; in other cases, one rather feels, or the patient even confirms this, if he is still capable of communication, that it has to contain strong forces of aggression that threaten to burst out from within. In other words, either the "way in" or the "way out" or possibly both can be blocked. In other cases, or even in the same patient at different periods, the tension erupts. Even then, in contrast to the often somewhat lame, diffuse behaviour of the hebephrenic, the catatonic loss of inhibition has something more dynamic and "contained" in it. As we have already shown it in one of the children, 11 year old Meera (114), the catatonic stiffness can represent a tense interlocking of contrasting impulses, an extreme ambivalence and ambivalence. The different components can either be balanced in a deadlock of rigidity that even takes the physical form of "frozen postures", or one may perceive an oscillation between them, perhaps in the form of some slight tremor, a stereotype gesture, or some verbal formulation, in which the latter half of the sentence may contradict the former one or even one and the same word may be a new combination of opposites. A movement of the head or hand may at the same time indicate "yes" and "no" ; the stopping on the threshold of a room indicates that the patient wants to be neither inside nor outside. We cannot describe the complete symptomatology here, but just want to give some impression, what to expect in the examples to be given later.

A third form of schizophrenia, the paranoid one (from Greek "para", beside, beyond, and "nous", mind, indicating that these patients think and talk "beside the

issue" or "beyond sense", but possibly also to be interpreted as "experiencing as outside the mind what really is part of themselves"), is usually developed in somewhat older patients. Though a paranoid colouring was noted in some of the adolescents, this was only an admixture in predominantly hebephrenic or catatonic states. Even amongst the 61 schizophrenic adolescents aged between 16 and 20 years, paranoid features were only dominant in 4 patients, all aged more than 18 years, while 18 presented a predominantly catatonic symptomatology and 39 were classified as hebephrenic. These figures amount to 2.2 per cent of all paranoid patients, 10.1 per cent of all catatonics and 28.2 per cent of all hebephrenics aged above 16. They thus confirm that hebephrenia is the form of schizophrenia most frequent at a young age.

Schizophrenia simplex, a less typical form, consisting in a gradual, insidious loss of interest and levelling down of all human emotions and aspirations, was not diagnosed in the group of adolescents. As the symptomatology in cases of this kind is very bland and little spectacular, it is quite probable that many young people affected by it can continue unnoticed within the shelter of a joint family or as "eternal students" or "notorious loafers", without ever being brought before a psychiatrist. Amongst the adults, we have only applied this diagnostic label to very few patients, and even then with some hesitation, as usually at least traces of a more active and definitely shaped symptomatology had moved the family members to seek help.

(b) Causes and origin.

Schizophrenia is still one of the great riddles, not only of psychiatry, but quite generally of human life. Practically each year, literature is abounding in new observations, suggestions and full-fledged theories that claim to have found "the cause" or at least an important contributing factor for schizophrenia. [For comprehensive summaries see (33) and (34)].

Some psychiatrists are still convinced that schizophrenia has its inevitable laws of heredity and try to prove the exact course of transmission ; others still scan microscopic slides of brain tissue for abnormal structures that might be "the seat" of the disorder ; alterations in liver function, intestinal intoxications, tuberculous infection and other grossly physical troubles more have been made responsible for it. In recent years, refined biochemical methods have succeeded in showing certain metabolic anomalies in schizophrenic patients, without, however, proving their universal significance. On the other hand, ever since Freud formulated his revolutionary theories about the role of the "unconscious" for human behaviour, research-workers and practical psychiatrists have not only explored the childhood histories, family constellations, test-responses, dreams, written and drawn productions of schizophrenics, but also developed ways towards understanding the schizophrenic way of life and therapeutic methods apt to lead the patient back into human community and more harmonious growth.

It will probably take years until, —if ever !—a “theory of schizophrenia” is worked out which can take account of all the various findings and opinions and reconcile them in a way that will satisfy everyone concerned ! Meanwhile, one promising tendency, maintained particularly by Manfred Bleuler’s school at Zurich, (see 34) (the son of Eugen Bleuler, who, at the beginning of this century, gave a first comprehensive description of the group of schizophrenias and coined many of the still current terms and concepts) is to seek no longer so much for common syndromes and symptoms and specific causes that would be basic in distinguishing “the schizophrenias” from any other type of mental disease, but to turn the attention rather to the individual schizophrenic patient and his unique existence. The schizophrenic symptomatology is no longer seen as something entirely new, unusual and bizarre, which is fundamentally different from any “normal” human manifestation, but rather as a possibility of life which, to a certain extent, can be dormant, concealed or even “privately admitted” in any human being. Under the influence of certain shocking and unbalancing experiences, which can be physical or psychogenic, and which can vary from one patient to another, the customary limits between “normal” behaviour and these less usual possibilities are shifted or, as one might say : “the split is brought out.”

Again, we cannot go into lengthy theoretical discussions in this context. Our task will be to examine, whether in the few young Indians who turned to schizophrenic patterns of life at the decisive age of puberty, any particular factors stand out as significant. Furthermore, we may have to see, whether already this small group of youngest adolescents can help us to answer some of the questions which Western psychiatrists are so eager to ask from any colleague working in a different culture : Are there more schizophrenics in India than in the West ? Has their number increased recently ? Does their symptomatology differ from that observed in the West ? Is the breaking up of the old social order responsible for any possible increase ? Is it true that, amongst people of traditional background or even of primitive tribes, acute, dramatic forms of schizophrenia, precipitated by shocking events, are more frequent than in the West and that also, by suggestive and authoritative methods of treatment, they can be “cured” promptly and without much after-effect ?—One sees, a whole packet of questions, which could probably be increased indefinitely. Partly we have already attempted to answer some of them, *e.g.* in the remarks on the cautions to be taken in any “transcultural” comparison of psychiatric phenomena, furthermore in the numerous references to the problem of emergence from collective forms of life into a competitive, individualistic society, and in particular by the investigations of factors that favour an autistic pattern in early childhood in the last chapter.

In the group of psychotic children, differentiation of ego-boundaries seemed to have been disturbed at the point of transition from the most primary empathic union with the mother to a stage at which at least a physical distinction between “I” and “not I” can be made. The young adolescent, in some way, has to go through a second birth. From a stage at which he was still safely embedded in the womb of the family, which fed him with the “breast-milk” of ready-made values and codes of behaviour, he

has to step out into realisation of his individual consciousness and personal responsibility. In facing new sectors of society, either while pursuing higher education, while already engaged in work or, particularly for girls, when entering married life, he or she has to resort to his own choice and discrimination. The rules of behaviour he has taken with him from his childhood environment, may no longer provide sufficient guidance. We have seen in the example of Vimal (100), a borderline case in the neurotic group, how at that stage "doubt" creeps in, the experience of being caught in between mere adherence to the customs and principles of the parental home and, on the other hand, following one's own insight and the line of conduct dictated by it. To be mature to accept the challenge of personal decision and responsibility, would mean to have acquired powers of self-control, of bearing frustration and resistance, of giving up immediate satisfaction for higher and more distant aims. If excessive pampering has prevented the growth of these qualities, or if neglect and excessive frustration have prematurely exhausted them, the call of the individual conscience may be heard, but to follow it will be, as Vimal (100) formulated it, "beyond the strength" of the young person.

Again, in a culture in which most of a life-time was spent amongst the people of one's own blood or at least one's own caste, social status and local origin, where a young boy very gradually and naturally learned to follow in his father's footsteps, while a girl was transplanted into an in-laws' family of similar background, possibly before she had already become aware of herself, there may have been less risks of suddenly being thrown into dilemma at so young an age. Individual firmness may have had time to grow before it was put to the test by any unusual life situation. On the other hand, however, continuing in the shelter of such collective emerging, may have prevented the development of individual consciousness. A young person may never have learned to stand by himself, without the constant, accustomed support of his surroundings. If, even at a later age, for instance when a son had to become head of the family on the father's death, this tight frame work finally collapsed, he may have discovered himself as what one of our patients called "a negative existence", *i.e.* as some one only held together and shaped by the support of his surroundings and without any firmness and limits of his own.

Amongst our adult patients, there are many who broke down quite late in life, at a point at which, for the first time, they became conscious of their individual responsibility and the necessity for choice. [See for instance the description of one case in the author's paper "A pattern of neurosis in India.", Hoch (35)]. What decides at such moments, whether a neurotic defence is sufficient to contain the overwhelming anxiety, whether a shell of psychotic withdrawal has to shut off all influence or whether complete chaos and disintegration overtake a helpless person, may be a subtle balance between the level of maturity and the quality, intensity and suddenness of the precipitating experience. At times, when no dramatic situation or conflict seems to be involved, one gets the impression that an imperceptible inner process of ripening, which has its own speed and rhythm, suddenly comes to a point at which it contrasts with the outward

circumstances in which the person is living, just as an embryo grows to a stage of maturity, which is no longer compatible with further life in the shelter of the mother's body. While, in the situation of physical birth, the womb itself expels the child, who has no means of clinging to it in stubborn refusal, these more subtle moments of birth from the shelter of a social "matrix" (The Latin word "matrix", derived from "mater", mother, does not only designate the embryo's nest in the maternal womb, but has come to mean any kind of mould that gives material poured into it its own shape, as *e.g.* the forms for the metal letters used in print), into individual consciousness and responsibility often have to be a more active venture, unaided by any expelling movement or any skilled obstetric assistance. Furthermore, the choice is open to refuse this "birth", though at the risk of stopping further growth. Just as, according to old Indian philosophy, rebirth after death is decided by whatever "access" one has gained to different worlds, the result of a "rebirth" of this type is determined by any immature attachments.

The present phase of social transformation in India exposes young people to outward situations which precipitate a need for individual consciousness and responsibility, before inward growth, still keeping to the old, slow rhythm, has reached the point at which this emergence can be faced with confidence. Viewing the problem in this way, would give us an explanation, why in the group of psychotic adolescents as well as amongst the neurotic children, we find so great a number of patients who had enjoyed what seemed to be normal parental concern and acceptance, while for the group of infantile psychosis harmful parental attitudes of some kind or other are universal : The small infant, whether mature or not, is pushed out of the secure womb into the unfavourable circumstances of an unharmonious family-life. The way back is impossible. For the older child and the adolescent, the moment of crisis may come when, from the safe, congenial "matrix" of the parents' care and affection, he has to venture out into a wider world. It need then not be the parental attitude in itself, which forces the young person into an abnormal reaction, but the contrast between the shelter it has provided and the world outside the family, which asks for different patterns of adaptation.

These reflections will perhaps seem a bit less hypothetical, if we add already now that 6 of the psychotic adolescents had been exposed to surroundings outside home : 4 girls through marriage, 2 boys in the course of their education. Of the remaining 5 adolescents, 4 had mothers with psychiatric disturbances, amounting to psychosis in 2 cases.

What other factors may have prepared the ground for a psychotic phase or finally precipitated it, will be demonstrated in detail in the following paragraphs.

(c) *Combinations.*

Two children with signs of mental deficiency since birth, went into psychotic phases of predominantly hebephrenic type at the approach of puberty. These 2 cases

which are not included in the Tables and Graphs for this group, are to be mentioned here :

- (127) *Godavari*, youngest of 5 children of a Kayasth clerk, lost her mother through tuberculosis, when she was aged about 6 months. After some time, the father remarried. The stepmother, who produced 3 children of her own, was described to be good to the girl, but rather strict.

Though, since early childhood, she had proved to be mentally limited, never able to learn, the family still expected her to get married. While already foolish, obstinate and somewhat withdrawn as a child, she started behaving in a definitely abnormal fashion at the age of 14. First she only went into occasional fits of trembling. About a month before she was examined at the age of 15, these fits were more definitely marked by anxiety and often by loud shouting. She suffered from lack of sleep and constipation. She often refused to eat and kept her fists tightly clenched. When she talked at all, the contents were "irrelevant". Altogether, a predominantly catatonic symptomatology. The author took her over as an out-patient from her predecessor in April 1956 : tense, scared, mute, physically dehydrated. A series of electro-shocks, already started, was completed to the number of 10 treatments. At the same time, tranquilizers were given. She recovered within about a month's time. 14 months later in July 1957, after having been sick with fever during an influenza epidemic, she was shown to us again in a state of excitement, talking in a confused, dissociated manner. As she was only brought for 2 consultations and then considered as "improved" by the family, we could not decide, whether perhaps this second phase only represented a psychotic episode due to the influenza (which at that time caused encephalitic complications in some patients !), or whether the schizophrenic disorder had assumed more hebephrenic character.

- (128) *Abdul Salam*, a Muslim boy, came from a big family. The elder brother, at 18, had already followed the father in his carpenter's trade. Of 2 elder sisters, one had died ; so the boy was the third surviving child. After him, 5 more brothers and one sister were born ; the latter and one of the brothers also died in infancy.

The father was described as a short-tempered and strict man, the mother as good-natured.

The boy learned to walk and talk at the age of 2 to 2½ years. Since infancy, he was weak and stubborn and went into temper-tantrums. When sent to school at 7, he could not learn. At the age of 2½, he sustained a head injury and after that frequently suffered from "bleeding nose". At the age of 10, he went through typhoid.

Shortly before his behaviour deteriorated at the age of 12, he had been sent to learn some odd jobs at a tailor's shop. Apparently he spent his time quarrelling and fighting and often got beaten by his master. Some of the remarks he made during the one interview, made us suspect that he might have been used for homosexual purposes.

The parents brought him, because he was unsteady in his work, escaping from the tailor's shop and roaming about. At night he was sleepless. He was reported to "hear voices" and "see strange things". At times he threatened to kill himself and others. While these obvious symptoms had only started one month before consultation, we were told that, already 4 months before, he had come home scared one night, maintaining that some "female ghosts" had tried to take hold of him and to carry him away.

The asthenic boy, with a slightly deformed spine and various abrasions and wounds all over the body, was brought tied up with a rope.

He complained of abdominal pain and nausea and about the beatings he had received from his helpless, irritable father. After this relatively realistic statement, he went into confused talk. He mentioned that someone had stuck a needle into his penis and that the knob of his thigh bone (Trochanter femoris) which he could feel sticking out, was a ball he had swallowed. He also told us that his stomach was full of coins he had eaten. In the doctor's office, he put the waste-paper basket on his head and danced about with it. When asked to repeat some story, he went into singing cinema tunes.

As he was not shown to us again after this first consultation, we can only guess that his demonstration of confusion, foolishness and lack of inhibition may have had the character of hebephrenia superimposed on congenital mental deficiency.

In both these cases, we cannot quite exclude that already the initial order, regarded as mental deficiency, may have been due to early autistic patterns rather than to a congenital defect of intelligence as such.

Amongst the adolescents counted as the "pure" group of psychosis, one girl presented slight signs of brain-damage; she was, at the same time, the only whose parents reported some abnormal behaviour since infancy.

While these are the only 3 cases of simultaneous combination of 2 mental disorders, *i.e.* 2 of mental deficiency (probably !), one of slight brain-damage with schizophrenia, some other cases showed a successive transformation of symptomatology, which left one rather at a loss, where to classify them.

In the group of "infantile psychosis", we presented the case of Ravindra (115) who was first seen at the age of 7, but who developed symptoms of a more adult type :

predominantly hebephrenic with some paranoid features, by the time he had reached the age of 13.

In the group of neurosis, we had seen one of the borderline cases, Fatima (90) going into definitely psychotic symptoms, when she was seen again after a long interval.

Amongst the adolescents labelled as psychotic, there are 2 who first impressed us still as neurotic : one girl with hysterical symptoms, one boy with severe compulsive habits, but who, during the period of observation, quite plainly went into psychotic disintegration. One girl, on the other hand, after going through a psychotic phase of hebephrenic type, later seemed to be able to secure herself by sticking to mild compulsive patterns.

These 3 cases seem to indicate that a neurotic defence and psychotic manifestations are not mutually exclusive. Though at any given stage one usually can draw the limit between them, they can follow each other. If the neurotic symptomatology no longer succeeds in filtering or padding communication to a tolerable degree, contact with reality can be broken off completely. On the other hand, on "picking oneself together" again after a phase of psychotic disintegration, one may find a certain safeguard in a neurotic defence.

(d) *Characteristics of our material.*

(1) *Distribution according to sex.*—While amongst the children in the group of infantile psychosis the boys outweighed the girls at a ratio of 3 : 1, the girls are far more frequent amongst the psychotic adolescents : 8 of them stand against only 3 boys. We have discussed, on an earlier occasion, the question, whether either certain biological processes or social customs impose strain earlier on girls than on boys. Considering that 4 of the girls in this group are married and that the psychotic manifestations were in close connection with this major change in their lives, one may be justified in seeking one of the causes for such early breakdown in girls in the marriage customs.

Amongst the older schizophrenic adolescents, girls and boys are almost equally represented up to the age of 18, while, for the age group between 18 and 20, the boys predominate at an approximate ratio of 2 : 1.

(2) *Distribution according to age.* (Graph 1b).—The age at which the psychotic adolescents were brought for consultation, is set off fairly well against the cases which we have grouped together under the heading of "infantile psychosis". The two eldest of these children, 10 and 11 years old, had both presented their peculiarities since infancy. The youngest boy in the group of "adolescent psychosis", was aged 13 at the time of consultation. All other patients were only brought at an age between 14 and 16. The neat gap thus established between the ages of the two groups is somewhat spoilt by the one mentally deficient boy (128) who showed signs of fairly acute psychosis at the age

of 12 and Ravindra (115), who was observed to develop from what one could call childhood psychosis into a hebephrenic state at the age of puberty.

Again, however, considering the often lengthy time-lag between first manifestation of mental trouble and consultation at a psychiatric clinic, these figures cannot be taken to indicate the actual age at which the psychosis broke out, and we have to complement the information given by Graph Ib by the 2 small Tables 23 and 24, one of them indicating the age at which the first symptoms were noted, the other one the duration of symptoms before first consultation. Even then, the onset for nearly all the girls and one of the 3 boys falls into the 2 years between 14 and 16. Two of the boys, however, had shown changes in their behaviour already between 11 and 13 and one girl between 13 and 14.

Table 23

Onset of symptoms in Psychotic Adolescents.

<i>Onset at age of :</i>	<i>Male</i>	<i>Female</i>	<i>Total</i>
11—12	1	—	1
12—13	1	—	1
13—14	—	1	1
14—15	1	4	5
15—16	—	3	3

Table 24

Duration of Symptoms before first Consultation in Psychotic Adolescents.

<i>Duration :</i>	<i>Male</i>	<i>Female</i>	<i>Total</i>
Up to 1 month	1	2	3
Up to 3 months	—	3	3
Up to 6 months	—	1	1
Up to 1 year	1	1	2
More than 1 year	1	1	2

Corresponding to the more or less acute nature and the often quite alarming character of the psychotic manifestations, we find shorter intervals between first symptoms and first consultation than for instance in the neurotic group. Six out of the

11 cases were examined within 3 months of the first appearance of symptoms, 2 girls even within 2 weeks. In the two cases seen by us more than one year after the first signs of illness had been noted, the onset had been more insidious. Most of the young people had already had some kind of treatment before we met them, ranging from naturopathic cold water treatment, prayer meetings, through the various schools of Indian medicine, to homeopathic, allopathic and even specialized psychiatric methods.

(3) *Reasons for Consultation and Main Symptoms.*—The general Table IV only sums up the main symptoms in very crude fashion, so as to suit all different groups. Psychotic manifestations, as a matter of definition, were of course present in all cases of this group, and they constituted "behaviour problems" in all except one boy. Subjective symptoms, in the form of anxiety or depression, were complained of by 8 patients. An intellectual disturbance in the form of lack of concentration was noted specifically by one of the boys.

A much more comprehensive and detailed picture of the symptoms presented by our young patients is given in the special Table 25.

TABLE 25

Main Symptoms in Psychotic Adolescents;

	<i>Male</i>	<i>Female</i>	<i>Total</i>
Excitement	2	8	10
Aggression	1	4	5
Depression, withdrawal	3	2	5
Mutism	1	—	1
Anxiety	1	3	4
"Fits"	—	2	2
Hallucinations	2	1	3(2?)
Paranoid ideas	2	2	4
Maniform behaviour	1	2	3
Excretory symptoms	—	2	2
Refusing food	1	2	3
Compulsions	1	2	3
Ideas of suicide	1	—	1

Excitement in some form played a role in all cases except one. It took the form of actual physical aggression in 5 cases. Depression and withdrawal were noted in 5 patients, in one of them as the main feature, in others alternating with excitement. The one boy who remained most withdrawn, had given up speaking almost completely

(mutism). Anxiety was expressed at some stage by 4 of the patients. Some kind of sudden, demonstrative behaviour termed by the relatives as "fits", was observed in 2 of the girls. The presence of hallucinations was definite in one case, while in two other cases one had to suspect them. Paranoid ideas were expressed by 4 patients. Expansive, maniform behaviour played a role in one of the boys and 2 of the girls. Two of the girls were so disorganized by the psychotic process, that they lost their normal inhibitions with regard to excrements. Two girls and one boy refused food. Some of the others expressed occasional suspicions that the food might be poisoned. The compulsive symptoms noted in one boy and two girls partly preceded or followed the main psychotic phase, partly were present even during it. Only one boy entertained ideas of committing suicide.

On the basis of these symptoms, one boy and 3 girls were regarded as predominantly catatonic, the remaining 2 boys and 5 girls as more hebephrenic.

The description of the symptoms, those reported by the relatives and those noted during the interviews or during in-patient treatment, will be found in the summaries of the individual cases.

If one compares our list with the symptomatology given as typical for schizophrenia in Western text-books, one will miss explicit mention of what E. Bleuler (36) called the "primary symptoms", *i.e.* the disturbance of associative thought and the alteration in emotions. No doubt, disturbances, of the thinking process were present in all cases. If they were not specifically noted, this may have several reasons: First of all, very young people, particularly if they are little educated, are not very much conscious of their own thought or at least, if they vaguely experience any alterations, might have difficulty in expressing them adequately. Such expressions as "man kharab ho gaya", "my mind has gone bad", as we heard them from some of the patients also in this group, may refer to such disturbance of thought. Amongst our older patients, the more educated ones were often able to formulate such disorders surprisingly freely and accurately. This, however, was a feature observed more in cases with gradual onset and in which a certain distance and self-criticism were still preserved. Once psychotic excitement has swept a patient completely away or when, as this was the case in one boy, he freezes into catatonic immobility and mutism, one is not likely to get much direct information about primary symptoms of disturbed association of thought, but one may be able to infer its presence from secondary elaborations, *e.g.* the patient's idea that someone has done magic on him, that he has been intoxicated, that his thoughts are being "stolen" or that they are being directed by some invisible rays. Sometimes one finds proof of dissociated thought in written products or drawings.

As to the lack of emotional contact and flattening of emotions, this is a phenomenon which the author has found much less typical in Indian patients than in European ones. The reason may be a quite generally greater emotional openness in Indians,

who are still far more used to empathic emotional communion than people in the West. One has, however, found even in the West that the schizophrenic patient is not totally incapable of emotional contact. He seems to withdraw, where the environment or in particular the observer represents to him someone who approaches him with grown-up demands and expectations. Where the observer, preferably the well-known psychotherapist, can create a relaxed atmosphere, in which the patient feels accepted as a child, at a level where even his least developed possibilities are no longer strained, contact can be established and many of the secondary symptoms disappear. The Western ideas of economic and social usefulness, which impose as a point of duty, honour and pride on any adult or even adolescent to show himself sensible, responsible, and "mature", seem to have blocked the freedom to constellate a child-parent situation far more effectively in Western people than in Indians. Particularly the foreigner is still experienced by many of the simple, unsophisticated Indian people as someone to whom one can appeal for help and protection as a child to a parent figure. Many patients, not only psychotic ones, and often also those of an advanced age, had no hesitation in verbalizing this even quite explicitly by telling the author : "You are my mother" already during one of the first interviews. The author can of course not exclude that, through her particular attitude of concern, she may have constellated this approach and that the same patients, to another observer or to the family-members whose claims they resented, may have appeared "out of contact".

If the inhibition against showing oneself as a child can be discarded so easily even in patients of a more advanced age, one need not wonder, if in the young schizophrenics of the group under discussion, emotional flattening and lack of contact did not seem to be prominent features. Only one boy was so depressed and withdrawn that little emotional relationship could be established with him during the few visits.

(4) *Local Origin* (Table III).—According to Table III, 5 of the psychotic adolescents lived in Lucknow, 5 in other towns of U.P. and only one girl in a village. While this latter one was not only of village origin, but also married into rural surroundings, one further girl had been brought up in a village, but moved to Lucknow through marriage. Two more girls, one married, one unmarried, though giving a town as their domicile, seemed to be rather of village type, one from the outskirts of Lucknow, the other one from a small town with rural elements.

Apart from the one girl who had been displaced from city to village through marriage, only one other patient, a boy, had experienced major changes of surroundings. His father had been transferred several times, and the boy himself had been to two different boarding schools away from home. One other boy had been away from home for educational purposes temporarily.

No children from refugee families are to be found in this group.

(5) *Community and Caste* (Graphs II and III).—While the psychotic children all belonged to the Hindu community, there are amongst the adolescents one Muslim

and one Christian boy and one Sikh girl. The great majority is to be found amongst the Hindus. The figure of 72.7 per cent, however, does not deviate significantly from the average of Hindu patients in the total material (70.7 per cent), while the one Muslim, with 9.1 per cent, remains behind the average of 19.7 per cent amongst all children. One may remember, that several of the "borderline cases" in the neurotic group, particularly amongst the girls, were Muslims, and that we had the impression that these patients perhaps rather corresponded to the psychotic than to the neurotic adolescents amongst the Hindus.

With regard to Hindu caste, the most striking fact is the presence of 37.5 per cent of patients from scheduled castes (average for the whole material only 8.8 per cent !), all girls who had been married early ! Amongst the rest, Brahmins and Kshatriyas, 2 each, make out a share of 25 per cent each, while the remaining one case is Baniya. In contrast to the group of infantile psychosis, where we found an unusually high percentage of Kayasth children, there is not a single case of this sub-caste amongst the psychotic adolescents, except for the one girl in whom hebephrenia was combined with mental deficiency and who does not figure in this count.

The number of cases in this group is of course too small to draw any detailed conclusions. The presence of 3 Shudra girls, however, does not only throw light on the role of certain marriage customs in upsetting young people, but also proves what we have mentioned earlier, for the organic-congenital groups : the more grossly disturbing and deviating from the norm the symptoms of a mental disturbance are, the more are we likely to see members of low social classes amongst the patients of that kind. This does not necessarily mean that such disorders are more frequent than others in these social sectors, but possibly only that milder and more differentiated disturbances do not impress the surroundings as pathological and that only very massive demonstrations allow the patient to draw attention to his conflicts or his needs. Her experiences outside the clinic, with largely illiterate mountain peasants, have furthermore made the author suspect that, amongst uneducated people, much neurotic tension does not find expression in any symptoms that would be taken as "mental", but quite simply in physical troubles, such as headaches, vague pains, palpitations etc., which are more often seen by the general practitioner and the hospital doctor than by a psychiatrist who would label them as hypochondriac or psychosomatic. If even the physical complaints can no longer "hold" the tension, complete psychotic disruption or withdrawal may be the only way out.

(6) *Occupation of Father or Guardian* (Graph IV).—According to the relatively high share of patients from scheduled castes, one will also expect a similar proportion of families from the classes with manual occupations. We find indeed that the fathers of 2 girls were occupied in farming (one a milkman), while one father, also of a girl, was a labourer in the building trade. While one of these girls, even after marriage, remained in the same social surroundings, the 2 remaining ones had to get adjusted to

different conditions. A girl brought up on a farm got a husband from a slightly more emancipated family, who was eager to continue his studies up to MA. The daughter of the labourer was married to a salesman, himself coming from a rather poor village family and somewhat lost in his city-surroundings.

Apart from the 2 girls from farms, we have in this group the son of a landowner of the old Muslim zamindar type. The boy had mainly grown up in the city or in hill-stations in very refined surroundings that had hardly anything to do with a rural atmosphere. Amongst the rest of the occupations, we find a distribution similar to that in the neurotic group, with a slight predominance of fathers engaged in business.

(7) *Joint Family* (Graph V).—In 3 of the cases, we know for sure that the patients, all girls, came from joint families. A further 3 definitely had grown up in small nuclear families, while the status of the remaining 5 families is not known for certain. Most probably, all the 4 girls who got married early came from joint families. Three of them lived with the in-laws after marriage, *i.e.* equally in an extended family; one seemed to spend part of the time with the in-laws in the village, part of the time with the husband in the city, but usually even then in the company of one of the women from the husband's family.

One girl, in whom we doubted for a long time, whether really to assume a disturbance of schizophrenic type or merely a more superficial reaction to unfavourable environmental circumstances, what one could call "waywardness" (in a rather awkward attempt at finding an equivalent for the German term "Verwahrlosung", which implies lack of care and safe keeping !), had grown up in a particularly typical joint family setting. In her case, the "multiplicity of parent-figures", which made her "everyone's child and no one's child", actually seems to have played a great role in the deficient formation of ego-boundaries.

(129) *Shanti* was the eldest surviving daughter of a Brahmin from the outskirts of a medium sized town in U.P. The joint family consisted of 87 members, amongst whom a lot of quarrelling, intrigue and rivalry went on. Shanti's father had functioned as a station-master for some time, but had retired and engaged in business, mainly forest-contracting. At the time when we met the family, he was already aged 49. A first wife had died early and left no children. Shanti's mother, the second wife, was 14 years younger than her husband. She was a fat, coarse person, who somehow impressed us as an "evil presence". She seemed to be possessively clinging to her daughter and rather resented our attempts at teaching her some discipline.

A first son of this marriage died at the age of 2. Two years later, when the mother was aged 20, Shanti was born. Being the eldest surviving child, she was pampered considerably during infancy. At the age of 3, she was somewhat displaced from

her favoured position by the birth of a brother. Later, 2 more brothers and 2 sisters were born, so that finally she was the eldest of 6 surviving siblings. By the time she was brought for consultation, the initial pampering seemed to have changed into a rather neglectful, careless or at least inconsistent attitude of the parents.

One cousin of the father was described to be mentally deficient.

As far as we could make out from the girl's own account and our interviews with the parents and other relatives, the children were brought up in a very haphazard way, without any discipline. Threats and false promises seemed to be used currently as inducements to obedience. What could not be obtained from one family member, could easily be had from someone else, if one was clever enough to utilize the complicated relationships of rivalry and temporary hostility. One can imagine that the value of truth and of any consistent, well-ordered behaviour was negligible under these circumstances !

Shanti was breastfed up to the age of 18 months. She learned to walk at the age of 1 and to talk at the age of 2. Her speech, however, only became fluent by the time she was aged 4 to 5 years. Even at the age of 15, her articulation at times was not very distinct, and she often talked in a rather circumstantial manner, which seemed to indicate some difficulty in associating ideas and words into logically constructed sentences. When she was sent to school, she could not learn. At the age of 15, she had picked up a few things by rote, and also had some idea about various household activities. Her knowledge, however, was patchy and superficial, without a firm basis of well assimilated fundamental concepts. She could, for instance, give a quite detailed account of various religious and social customs, which apparently in this Brahmin family were fairly carefully kept and perhaps formed the only reliable frame of order ; but she had no idea about the deeper significance behind these performances. The eternal refrain, indicating identification by mere imitation, without any attempt at real "incorporation", was simply "Ham log aise karte hae.", i.e. "We people do things in this way." She could automatically recite the "tables" up to 4 times 6, but had no direct concept of number nor any idea about the value of money. She obviously had learned to spell in Hindi, but seemed to be just too careless to give each letter its proper place and significance in attempts at reading. Though this apparent lack of any fundamental concepts and abstract mental representation at first struck one as possibly due to a congenital mental defect, we had occasion, during 3 months of in-patient treatment and some additional interviews after her discharge, to note that the girl certainly knew more than she pretended, but that she was "hoarding" her abilities to protect herself from being "used". Furthermore, not only her thinking, but also her inconsistent behaviour, seemed to be less the consequence of any basic lack of understanding, than for more the result of a chaotic, undisciplined upbringing. We do not know, how far this same family

atmosphere had also had its harmful effect on the other children. Shanti may have been singled out, not only by her position as the eldest surviving child, but also through the fact that, unknown to her and the family, there were signs of some brain-damage : the limbs on the left side were somewhat spastic, with increased tonus and reflex responses and a pathological plantar reflex. As the occasional fevers, including chicken-pox at 5, multiple boils at the age of 10 months, were not likely to have caused this lack of symmetry, one had to assume that it was of prenatal origin.

While, as long as the girl counted as a child, no one seemed to care much about her lack of understanding and discipline, the parents began to get concerned about her, when she approached a marriageable age. Menstruation had started at the age of 14, the year before we first saw the girl. She was physically well developed, but had a rather childish facial expression. Her occasional remarks and her at times very uninhibited behaviour with regard to male fellow-patients, made us suspect that she had been exposed to some sexual experience, possibly within the large family. On the other hand, she seemed to have a horror of anything that had to do with marriage and childbearing. Whatever experience the girl may have gone through, it was kept very tightly concealed as a family secret. An uncle, who lived at a distance and who emphatically disapproved of the chaotic conditions in the joint family, also shared our impression that the girl had been corrupted.

The risk of serious harm to the family reputation through further happenings of this kind was probably what made the parents so astonishingly ready to place the adolescent girl under our care as a resident patient ! Even in other respects, she obviously could no longer be controlled at home : she would roam about and approach people even outside the family with an utter lack of distance and inhibition ; she did not obey anyone, and went into violent fits of temper when anything went against her will. Furthermore, the parents complained about her lack of concentration and her indiscriminate, greedy eating. We also found out that she had taken to chewing tobacco, obtained by stealing, and that she had also got used to eating some leaves which were supposed to contain an intoxicant.

The girl herself, sturdy, plump and fairly tall for her age, only complained of occasional headaches.

Close observation as an in-patient soon showed us her lack of distance, her diffuse sense of reality, her moodiness and her childish, mischievous behaviour. The whole world seemed to her to be one big joint family in which she, as the eldest and at one time only child, could approach any one without the slightest regard for the other person's position or inclination. Reality could be twisted and juggled with so as to suit her needs : she would try to gain sympathy by falsely accusing

others of having harmed her. At one point, she tried to maintain that the male attendants were molesting her, while she was really the one who tried to seduce them in a manner that undoubtedly testified to some experience in this respect. She would pick a quarrel with her room-mate and then suddenly alarm the whole staff by howling and complaining of an attack performed on her, the innocent one. At times she could fight like a wild cat, for instance when once she was to be locked into her room as a punishment for her disturbing the peace of the ward. At that time, we got the impression that any measure that threatened to resist and to limit her in her unbounded, uninhibited use of the surroundings for her exclusive pleasure, created intense anxiety and fear of annihilation. Often it was difficult to distinguish, whether her behaviour was the deliberately calculated effect of ruthless selfishness, or whether it simply stemmed from her deficient grasp of reality, her inability to see the world as anything else but a convenient arrangement that could be juggled into providing satisfaction for her own needs and uncontrolled moods.

Though drugs were helpful in calming the girl's tendency to fits of temper and her lack of inhibition, the main therapeutic effort had to consist in patient attempts at teaching her some discipline, some consciousness of an order of reality that could not simply be avoided or pushed over, and some understanding for the feelings of other people and the effect her uninhibited behaviour had on them. For some time it seemed, as if this method had some success. One of the rewards for "good behaviour", which provided at the same time a legitimate outlet for her need to draw attention, was permission to produce herself with dancing during the weekly entertainment evenings for the patients, who good-naturedly tolerated her antics. In the beginning of the treatment, even these performances betrayed a quite autistic disregard for any imposed order : The music usually a gramophone record of her own choice, merely seemed to be a customary requisite. She seemed to be incapable of understanding that her dancing movements should have been in harmony, not only with the rhythm, but also with the emotional quality of the music. Later, when she had begun to grasp some elements of discipline, she at least respected the rhythm, but still could not enter into and match the emotional shadings of the tune. At the same time, one could note in her performance, the development of some feminine grace, but also of seductiveness, while first she had only created the impression of a frolicking child. Even these traces of budding femininity, however, often had more the character of an accidental success in imitating some film actress and not yet of something that had really become her own and that was under her conscious control.

We realized, how little our efforts had managed to penetrate and how strongly the home atmosphere still tempted her to persist in her chaotic lack of restraint, when, after her Diwali leave, when she was supposed to come back for another phase of in-patient treatment, she produced a violent scene in our waiting-room before the assembled relatives. The family implored us to take her again, as

they had been able to note the beneficial results of our "training". It was impossible to say, whether the demonstration served the purpose of avoiding return into the strict discipline of the clinic or whether, on the contrary, she wanted to show, how much she still needed further treatment. We decided, at any rate, to let her bear the consequences of her uncontrolled behaviour and refused to admit her, unless she herself should agree to further treatment. She spent some time with her uncle in Lucknow, who was very reluctant to take her and who occasionally reported about her, mentioning her absolute disregard for the common world of reality. Nothing is known about her further fate.

Apart from the uncontrolled outbursts of anger, the symptoms in this case were not very dramatic. What made us diagnose a hebephrenic state or at least a puberty crisis with schizophrenic features, was the basic autistic attitude, the diffuse, superficial thinking and the general lack of inhibition. One can, however, imagine that the girl, who within her own family had managed to get what she wanted without any more demonstrative symptoms, might have gone or still might go into more typically schizophrenic patterns, if at a young age she were to be transplanted into a family of in-laws who would have less tolerance for her indiscipline and "uselessness" than her own family and less understanding and patience than the clinic staff !

This case seems to point to the fact that autistic patterns of living can be tolerated and concealed within surroundings of a certain traditional type. They may only "come out", when the person in question has to leave this framework or if he grows to a stage at which even this tolerant environment would expect a different behaviour. Talking of "latent schizophrenia" does not really solve the problem. It may be more realistic to admit that there is no such thing as a "schizophrenic illness" which will be recognized as such under any and every circumstances, but that certain patterns of behaviour only assume "nuisance value" and the character of a recognized disease within a particular social context.

(8) *Lack of Parents* (Table VI).—The figure for "lack of parents", with 27.2 per cent, is the highest amongst all groups, almost 3 times as high as the average for the whole material. In properly evaluating this figure, one has to remember that the group of psychotic adolescents only contains patients of the oldest age-groups. In mere terms of time, there is therefore more chance that they should have lost one of the parents through death. The father of one girl had died shortly after her marriage ; both parents of another married girl died after she had reached the age of 12 ; only one girl had to miss her father since the age of 5. The one girl whom we presented as a probable combination of mental deficiency with hebephrenia (127) had lost her mother at the age of 6 months.

None of the parents were separated or divorced. One boy seems to have lacked proper parental care, because his mother was working as a teacher. He is the same

boy who also was uprooted several times during childhood through the father's transfers and his being sent to at least 2 different boarding-schools :

- (130) *Thomas*, a Christian boy from a city in U.P., was first admitted at the Psychiatric Center by the author's predecessor in November 1955 at the age of 14. At that time, 2 weeks after having suffered from a fever, he had manifested "strange behaviour". He went into fits of excitement, could not sleep at night and kept singing, whistling and playing his mouth-organ most of the time. He expressed the idea that "people were after him", trying to tempt him into doing bad things. He talked about seeing girls or men with faces like Hanuman, and he could also hear their voices, sometime "through the telephone", and would go into loud conversations with them. He also complained of some unusual smells, apparently olfactory hallucinations. All these symptoms were aggravated after the parents had taken him to a prayer meeting. After 3 months' treatment with insulin-subcoma, chlorpromazine and electro-shock, the boy was discharged as "socially remitted".

In September 1957, *i.e.* shortly before or after completion of his 16th year, the author also got to know the boy. The parents reported that he had presented signs of excitement and confusion after having been sent to a new boarding-school. At that time, our investigations gave the following picture of the family and the boy's development :

The father, a rather stern, quiet and withdrawn man, who seemed to hide many problems, had originally been a clerk. Later he devoted himself completely to work for his Church. His wife was also described as very religious-minded. As already mentioned, she worked as a teacher. She impressed us as a hard, strictly disciplined and matter-of-fact person, who had no understanding for this son's sensitivity. Neither of the parents ever seems to have had time for the children. Thomas was the third amongst 6 children ; one sister and brother were elder, 3 brothers younger. There seemed to be much rivalry between the delicate, slowly developing patient and the next younger brother who, though born 2 years after Thomas, had caught up with him physically and intellectually.

Sent to boarding-school already at the age of 7 and later transferred to various day-schools, the boy had got 2 years behind his age. He was particularly weak in mathematics, while he showed a certain interest in manual occupations and in music.

Before his illness, he had been a dutiful, reliable and helpful boy. He was fairly sociable, but at times short-tempered. Already a few months before the first psychotic phase, sibling rivalry had created increasing tension, and once a violent quarrel between the brothers had taken place. The hallucinations, however, had only set in 2 weeks after the febrile illness.

When the boy was brought again in 1957, he had been admitted, about 2 months previously, to the same boarding-school at which 2 of his brothers had already been studying for some time. On arriving there, he found that his brothers' fellow pupils knew all about his previous phase of illness and therefore had spread the rumour that he was "mad". He had to bear a lot of teasing about this and could not make any friends. To the meek, obedient boy, the more mischievous and rebellious behaviour of the other pupils seemed "naughty" and threatening. After about 2 months at this new school, he had to be taken home because of excitement and confusion.

By the time we examined him, he was more depressed, quiet, withdrawn and somewhat anxious. No active symptomatology was noted. But it is quite possible that the brothers' and the fellow pupils' teasing may have taught him to conceal what could be considered as "pāgal". During one week's observation at the Center, he hardly talked. When faced with the Thematic Apperception Test, he only gave very scanty answers to 5 of the 20 cards. He seemed to be mainly concerned with the clothes the figures in the pictures were wearing and did not pay much attention to the emotional content. He insisted himself on leaving the clinic as soon as possible; probably he feared that this renewed hospitalisation would mark him even more as a "lunatic". Our attempts at winning the father for some indirect treatment through opening his understanding for the boy's needs, had no success. He too seemed to be out to avoid any contact with psychiatry for fear that this might reflect on his sanity. This example once again shows that a child whose parents are both living, but directing their interests to concerns other than the family, may be worse off than a child who may have lost one of the parents, but still enjoys the sympathy and care of some family members. Furthermore, any such lack of parental care need not affect all the children in a family in the same harmful manner. Our patient's brothers seemed to thrive quite well under the same circumstances. Thomas, however, more delicate and sensitive and with a slower rhythm of physical, intellectual and emotional development, probably would have needed more maternal warmth and paternal interest than he actually got.

(9) *Heredity* (Tables VII and VIII).—In 7 of the psychotic adolescents, *i.e.* 63.6 per cent, we had been informed about or we ourselves were able to state some psychiatric disorder in the family. Only one distant relative was reported to suffer from mental deficiency, *i.e.* a defect of congenital type. All other troubles signalled were functional. "Specific heredity", *i.e.* the incidence of other schizophrenic psychoses in the same family, amounts to 27.3 per cent. This figure, as well as the total figure for "heredity", which we gave with 63.6 per cent, coincides with the figures for "parental heredity". In other words: wherever any psychiatric morbidity was signalled in any family, it affected at least one of the parents, either exclusively or in addition to other family-members. Two mothers and one father had manifested psychotic features, while 2 fathers and one mother impressed us as highly neurotic. One mother, that of Shanti

(129), has been noted as a "strange character", as information and our own observation did not allow us to decide, how far any psychotic process or neurotic development might have been involved in bringing her to the state we noted.

Of the two mothers listed as "psychotic", this diagnosis was based in one case on our impression and the girl's account of the mother's behaviour. The degree of suspiciousness she displayed, her superstitiousness and her possessive, overprotective clinging to our patient, the youngest of 8 children, suggested a paranoid development. As the atmosphere created by this mother, who somehow impressed us as an "old witch", seemed to have played a part in the girl's development, we give the history, though it is rather rudimentary. Probably mainly due to the mother's suspiciousness and her possessive hold, the girl was not brought back after a first consultation.

(131) *Rajkumari's* father, a Kshatriya police officer in a small town of U.P., had died of heart-attack, when this youngest child was aged 5. He had been a sociable, cheerful man. At the time of his death, the 2 eldest sons and one daughter were already settled in life. A further son got married and went into farming a few years later. One son had died of small-pox. The 2 youngest sons, 3 and 5 years elder than *Rajkumari*, were still studying at the time when we met the family.

Rajkumari was born, when her mother was already 42 years old. She was breast-fed for 2 years. As long as the father lived, he pampered her as the youngest child. She was taught at home and, at 14, had mastered the programme of 5th class. She took some interest in music and housework. Since early childhood, she had been rather nervous, apt to make a big fuss even about minor physical troubles. At times she went into fits of anger.

Menarche was dated at the age of 12. During each menstrual period, the girl suffered much pain. Also at 12, she went through typhoid and was unconscious in a state of high fever. She had, however, completely recovered from this illness, when, about 2 years later, shortly before the Holi festival, she suddenly got scared, when lighting a fire. She told the mother that she had seen some women in coloured sarees who wanted to attack and kill her with swords. 25 days after this incident, which seems to have brought out some latent tension in rather dramatic form, she started complaining of headaches and at times had "fits of unconsciousness". Later she became excited, tore her clothes and threw about any article she could get hold of, so that she had to be tied up. She would sing, but refused to talk and only tried to communicate by strange gestures. She even went to the extent of playing with her own excrements.

Physically, the girl was well developed, of rather sturdy, pyknic type. There were no signs of any physical trouble, in particular no neurological anomalies. During the one consultation, she seemed to be in rather depressed mood, not speaking, but at times showing a rather mysterious smile.

We diagnosed the catatonic form of schizophrenia, but, in view of the only vaguely described fits of unconsciousness, left open the possibility that the psychosis might have had an epileptoid basis.

The act of lighting a fire was described by several of our adult female patients as the moment at which some acute excitement broke out. Fire can of course be a symbol for human passions, and a sudden outward flare may find an inward resonance. The play of light and shadows, which tempts even "normal" human beings in certain moods into playfully imagining colourful and mysteriously moving ghosts in the dancing flames of a fire, may lend an appropriate form to anxieties and tensions which have been suppressed to bursting point. Furthermore, there seems to be some belief amongst little educated people that, having to work near the fire, gives headaches and other nervous symptoms and that, therefore, a woman in an unbalanced or delicate state of mind should not go near the hearth.

The mother's superstitious nature had probably not only encouraged similar tendencies in the daughter in our case, but also promised a credulous audience to a manifestation of this kind. Unfortunately, this very suspiciousness and diffidence in the mother also acted against her developing any faith in our treatment.

The girl was not brought back after a first visit ; so we were not able to explore the nature and degree of the mother's disturbance and its influence on the daughter more thoroughly. The early death of the father was likely to expose this youngest child quite particularly to any unhealthy effect of the mother's paranoid trends.

Our information is more accurate with regard to the other two families in which one of the parents was psychotic :

- (132) *Lalli's* family already knew our Center, because the father, a milkman, from the outskirts of Lucknow, had been treated by the author's predecessor, 3 years before the daughter fell ill. The scarce notes kept at that time only allowed us to find out that, at the age of 52, he had been given a series of electro-shocks in a state of maniform psychosis. Whether the manifestations were of a typically cycloid kind or whether they suggested a schizophrenic admixture, could not be ascertained. Three years later, at any rate, he seemed to have completely recovered. The girl's mother was described as patient and loving.

Of 10 children, 4 had died in infancy. Lalli was the 4th of the 6 surviving ones. One brother and 2 sisters were elder, one brother and one sister younger. She got some education at home and, as long as she was under the care of her parents, showed no signs of any mental deviation. At the age of 12, she started menstruating. One year later, at 13, she was married. At the time when we saw the girl, aged 14, she had already been living at her in-laws' house for some time, but, as far as we know, she had not had intimate contact with her husband

yet. The still childish girl, who had probably imagined her future husband as a flawless prince, was disappointed to find that he was dark-coloured. The in-laws were unkind to her and finally, keeping back her jewelry, sent her back to the parents. As she was brought by her parents and as we could not see anyone from the husband's family, we do not know, whether already at the in-laws' home she had presented any signs of mental disturbance.

All we know is that, 2 weeks before the girl was brought to us, she went into a sudden fit of "unconsciousness", while fetching water from the municipal tap. Then she started weeping, talking irrelevantly and tearing her clothes.

One will have to realize that, when uneducated people talk of "unconsciousness" ("behosh"), this does not necessarily mean a complete loss of consciousness in the sense of fainting or an epileptic fit. It may simply mean that the person lost control over herself, acting without "recognizing" her surroundings and without being "conscious" of her doings, *i.e.* a state of altered or shifted consciousness, but not total unconsciousness.

The girl presented no neurological disturbances. She was untidily dressed and made herself stiff during physical examination. She performed odd gestures with hands and feet and changed from singing and dancing into weeping without any obvious reason.

After a week, the family estimated her probably very temporary improvement, obtained with a sedative, as sufficient and did not bring the girl back.

One may hesitate, whether to call a case of this kind really schizophrenic or whether still to count it as a simple hysterical manifestation. The precarious situation of a girl from a poor family, who has been "sent back" by her in-laws, certainly invited escape into illness. It may not be accidental that the acute onset came in a situation in which, at the public water-tap, the girl was exposed to the stare and probably also to the gossip of her neighbours !

If one considers cases of this kind, which certainly present quite a few of the classical hebephrenic or catatonic features, but are characterized by a dramatic onset and often a speedy recovery, as schizophrenic, one would have to give a positive answer to the questions of Western psychiatrists, who want to know, whether in "primitive" people schizophrenia is frequently released by shocking events and equally easily "cured" by little therapeutic effort and within a short time. Probably only prolonged follow-up of cases of this kind and a very detailed history and clinical investigation could decide the issue. Usually, however, these very cases, because the families are reluctant to seek modern methods of treatment and to persist in them after some initial success has been gained, are not available for thorough exploration or observation.

- (133) *Krishna Kumari's* mother was treated at our Center in November 1958. We shall first give her history, as it was known to us 3 years before the girl was brought for consultation :

She was the only surviving daughter, between 2 brothers, of a farmer. At the age of 14, she got married to a woodmerchant, a kind, but somewhat helpless and clumsy man. Both were of the Baniya caste. They lived in joint family ; but at the time when the mother was brought for treatment, she was the only adult female member in it. She had not had any formal education and had not even been taught any housework. Her husband described her as lazy, careless, stubborn and moody.

Krishna Kumari was the first child, born when the mother was hardly aged 16. After one more daughter, 5 sons followed. Of these, however, one died of small-pox, and the two youngest were not born yet, when the mother went through her psychotic phase. Already in 1958, the mother resented her big family. After the 4th child, she thought of an operation for sterilisation, but then had the baby at home and left things as they were. She often refused the husband's intimate approach and, during pregnancies, had attempted abortion, but without success. The husband also agreed that no more children should be born, but was too ignorant and helpless to undertake any precautions. Even after we had given some instructions about contraception, 2 more children were produced.

The mother told us that she felt her mind going weaker, after she had given birth to her first 3 children. Already soon after marriage, however, she had experienced attacks of anxiety and restlessness. She felt insecure and lacked confidence in her own abilities to manage household and children. It seemed to her that the family did not approve of what she did. For the last $2\frac{1}{2}$ years before we first saw her, she had had occasional "fainting spells". According to her description, they were probably of hysterical nature. These fits continued up to one year before consultation. Then, after birth of the 5th child, doubts about the husband's faithfulness, which she had already entertained for several years, became more pronounced. She also developed the idea that every one in the house was "saying things against her". She started abusing the customers who came to buy wood. Finally she alarmed the family by pointing out that a picture on the wall had become "real" and that the river depicted on it was flowing all over the house. At the same time she suffered from sleeplessness and headaches and became moody and angry.

At this point, she was brought for consultation. She complained of restlessness, anxiety and a sense of helplessness and depression. She was no longer sure, whether she was talking properly or not, and she knew that the other people in the family regarded her as mentally ill. At times she felt like committing suicide. She was quite open about her unwillingness to have any further children and

about her sense of inadequacy as a housewife and mother. She came for a second interview after an interval of 10 days and reported significant improvement through the medicines we had prescribed.

At that time, our young patient Krishna Kumari was aged 10. One can imagine that the mother's illness was quite consciously experienced by her and that, moreover, she may have had to take over some of her mother's duties.

About her earlier development, we know that she was breastfed for $1\frac{1}{2}$ years, that she started walking at one year and talking at $1\frac{1}{2}$. At 2, she had a severe attack of small-pox. At 4, she was already sent to school. She only began to get interested and to develop her abilities, when she was transferred to a different school a few years later. At the age of $13\frac{1}{2}$, she failed in 7th class. She explained that previously, when changing school, she had been granted a double promotion and had had difficulties in catching up with her new classmates. At the time when she was supposed to learn for her exam., there were visitors in the house and she had to do a lot of work for them. She was rather disappointed when, after this failure, she was not allowed to continue her schooling. As a consolation, she was sent to a sewing-class. Just about at the time when she had to digest her failure in school, she also had her first menstruation. Though she had always been somewhat sensitive, irritable and stubborn, the strain of these experiences first did not seem to affect her adversely. One has, however, to conclude that secretly the tension had been mounting. It spilled over a few days after she had been attending the funeral party of a neighbour, where probably she heard all kinds of old wives' tales about death and similar subjects. On Dussehra day, while she was cooking, (again the proximity of the fire !), she suddenly got upset. She anxiously complained that her mind was failing, that she could no longer remember anything. A few days later, she started abusing, running about and throwing things in all directions. She did not sleep at night and was so restless and excited that she had to be tied down.

The 14-year old girl, slim and gracefully built, with pretty features, complained of anxiety, confusion, "noise in the ears" (probably elementary hallucinations, *i.e.* an auditory impression without "real" correlate, which is still undifferentiated and has not yet taken the form of a particular "voice") headache and constipation. Her voice was hoarse from constant shouting and talking. Apart from a slightly enlarged thyroid gland, as one often finds it in girls at the start of puberty, physical findings were normal.

During the first consultation, she was confused, anxious and suspicious. In her talk one noted superficial associations and alliterations. Anything that was said, was immediately taken as a reproach by her. This feature in particular reminded one of the mother's feelings of inadequacy and ideas of reference during her psychotic phase. Again, however, neither the occurrence of the psychosis

itself nor its partial resemblance to the mother's illness can be taken as a strict proof for any biologically transmitted hereditary factor. Both, mother and daughter, reacted to similar situations of being over-loaded with tasks for which they were not adequately prepared : the mother as a pampered only daughter had never been taught her future tasks of a housewife and was overwhelmed by her increasing duties as a mother ; the girl, as the eldest, had to take over household duties, not only during the mother's psychotic phase, but probably from a quite young age. Her failure in school was not only due to her excessive engagement in housework, but probably formed a welcome excuse for the mother to keep her at home and to transfer even more of her own load onto the delicate girl.

Both parents cooperated well and brought the girl regularly for control visits, on the whole 7 during a period of 5 weeks. At the end of this time, with the help of suitable drugs, she could be considered as socially remitted. While, once the first excitement had calmed down, she first was shy and embarrassed about her unrestrained behaviour, she was relieved later to find patient understanding for her problems. The mother too took this opportunity to get further advice for herself. Though she had been keeping fairly well since her first phase of treatment, even gaining weight quite considerably, she still suffered from headaches and occasional giddiness. These symptoms, very probably psychosomatic signs of some remaining tension, reacted promptly to mild treatment. Of course, at that point, we very urgently advised the parents to protect themselves definitely against further progeny. The father seemed to be willing to have vasectomy performed on himself.

Of parents whom we considered as presenting obvious neurotic disturbances, we have already presented Thomas' father (130). An example of a neurotically clinging mother of a boy and a father with asthma will be given later.

If sibling mortality (Table IX), with 63·7 per cent of all families and 18·5 per cent of all their children, is remarkably high, one again has to take into account the fact that this group only includes children of the oldest age-groups. This means that, in comparison with groups that contain younger patients, there is not only more likelihood in terms of mere time that some siblings may have died, but also a greater risk that some of these siblings may not have benefitted yet from the more advanced prophylactic and therapeutic measures that have saved the lives of children born during more recent years. Three of the 7 families in which one or more children died in infancy are the same ones in which psychiatric morbidity in the parents had been noted ; in the remaining 4 families, no mental illness or significant deviation had been signalled.

(10) *Number of Siblings and Position in Sibling-Row* (Tables X and XI and Graph VI).—Even if one remembers that, for the adolescents in this group, the chance of belonging to a completed family is greater than for the smaller children in other groups,

one is surprised to find, in Graph VI, that most of the young psychotics came from relatively large families. With the exception of one boy, all patients belonged to families with at least 5 children. In 3 families, 10 children had been born, but not all were surviving. One will now naturally wonder, what positions our patients took within these large groups of siblings !

The possible number of special positions, owing to the lack of smallest families, is not great. It is exceeded by 13.3 per cent for children born and 12.9 per cent for children surviving by the actual share of special positions amongst our patients. First born or first surviving children only exceed the possible maximum very slightly. The only single position that occurs far more frequently than one would expect, if risks were equal for any position, is that of the eldest daughter. 5 of the 8 girls were in this position, one of them first born, one first surviving, the other 3 only first of their sex, following elder brothers.

In the case just quoted, of Krishna Kumari (133), we have seen, what a burden this position can imply, particularly if the mother is out to relieve herself of her own load onto the shoulders of the eldest daughter. For Shanti (129), on the other hand, her being the first surviving child meant excessive pampering, at least during the first years of her life. The 3 other girls who were first female children, all were married early. All of them had been treated with over-indulgence while still in their own families and then they resented the lack of such special attention and the unaccustomed duties in the in-laws' families.

Rajkumari (131) who has already been presented, is the youngest child of a widow. Thus only 2 girls held inconspicuous positions in big families. One of them, Lalli, (132), reacted with psychotic manifestations to early marriage, ; the other one broke down, when the marriage of the elder sister promoted her in to the role of "eldest daughter" in the home.

Amongst the boys, only one has a special position as the only son amongst 4 sisters. One will remember that the position of the only son is represented with extraordinary frequency in the group of psychotic children ; we have discussed some of its implications in that chapter. This one only son in the group of adolescent psychosis, had quite obviously become a victim of his uniqueness. Though we do not know much about his infancy, the early start of the psychotic manifestations already at the age of 12, before he showed any physical signs of puberty, the probable existence of compulsive patterns even before that time, his intellectual precociousness and his quiet and brooding nature, bring him almost as close to the group of infantile psychosis as to that of adolescent psychosis.

(134) *Onkarnath's* father, a Hindu bank manager with some private property, was a rather nervous man, suffering from asthma. Since early childhood, he had been giving in to every wish of this only son and impressing on him the fact that,

one day, he would be the sole heir of all the family-property, as neither on the paternal nor on the maternal side any other male issue had been born. So the boy had been brought up in full consciousness of his own importance and uniqueness. The mother was a calm, religious-minded woman. She seemed to have some insight into the harm her husband had caused to the boy by boosting his sense of pride and omnipotence, but was helpless in undertaking anything against it, all the more as, in any critical situation, the father would go into severe attacks of asthma. Her mother, *i.e.* the boy's maternal grandmother, was described as compulsively orthodox about religious practices and cleanliness. Onkarnath was born after 2 sisters, one and 4 years older, and followed by 2 more sisters, 6 and 7 years younger. 3 more pregnancies ended in abortions. It seems that the next elder sister also was intellectually precocious : at the age of 14, she was already enrolled in a BA-course ! Onkarnath, at the age of 13, had reached 10th class. His general knowledge, due to much private reading, was however far beyond his age. He could keep up an intelligent conversation on many subjects with any educated adult on a quite equal footing and sometimes would come out with amazing bits of specialized information,—a real “living lexicon” !

Unfortunately, as the father “did not remember” and the mother was seldom available for information, as furthermore, discussion of immediate measures often was so urgent that everything else had to be pushed into the background, we have practically no information about the boy's early upbringing. All we know is that, for 6 years, he remained the youngest child and that, as the only son and heir, he did not only get all his wishes fulfilled, but that he also enjoyed respect and almost worshipful attention without having to make the least effort to prove himself worthy of such favours. As he had a very lively intelligence and good memory, not even the school programme presented any obstacles that could have made him conscious of any resistance or frustration.

At the age of 5, he sustained a head-injury through a fall. No untoward consequences were noted. Later, he was once treated for anaemia. At the age of 12½ years, 6 months before the first consultation, he had suffered from typhoid with several “relapses”. After this illness, he remained constipated.

Already before this attack of typhoid, however, he had not only been quiet and brooding since early childhood, but had started to show signs of anxiety and developed a compulsive habit of prostrating himself in any temple he passed or even of deliberately going to temples. When we first met him, he had a wheal of hardened skin on his forehead, as one sometimes finds it in very devout Muslims. He would also repeatedly salute the sun and the stars and pay excessive attention to such ominous happenings, as *e.g.* the twitching of an eye. The parents' reports about the time preceding the more distinct manifestation of psychotic symptoms were never quite plain. One felt that the father wanted to hide

or ignore many things that went against his ideal image of this only son, and that he had also instructed the mother to keep silence. We vaguely know that, by the time the boy was brought to us, he had already undergone prolonged treatment at a nature cure establishment. Furthermore, there was some evidence that he had got into "bad company", where he had had some homosexual experience with older boys. The father considered him as quite innocent with regard to sex. His behaviour with our staff-members and his fellow-patients during his most disturbed phases, however, made one guess that his universal knowledge also covered this field, even in its less scientific aspects! It seems that, what finally upset the precarious internal equilibrium completely, was the 9th class exam. Weakened by the attack of typhoid shortly before it, Onkarnath was not able to do as well as he had hoped. Furthermore, he found himself in a situation of dilemma during the tests ; His neighbour, older and physically stronger than him, asked him for help with one paper. Onkarnath, on one hand, feared that the cheating might be discovered and that he might spoil his result ; on the other hand he apprehended reprisals by his fellow-pupil, if he did not satisfy his demand. During his illness, he even hinted that the boy had threatened to kill him. It is quite possible that some fear of blackmail because of homosexual practices may have terrified him. He resisted the temptation to cheat, but after the exam. went into increasing anxiety and depression. It seems that this experience, perhaps for the first time, had put him into a situation in which he had to make a responsible choice without being able to avoid stress and discomfort in either way.

Again, as in some of the neurotic adolescents, one could observe attempts at investing the growing tension in a variety of different symptoms : When we first examined the boy, about 8 months after he had presented the first obvious compulsive habits and 6 months after typhoid, his complaints first impressed one mainly as hypochondriac. He was anxiously preoccupied about his abdomen. He would not let anyone touch it and even gave special warnings and instructions about not spoiling anything in it, when the doctor performed the physical examination. He kept his pyjamas tied very loosely, so that the strings should not press on his internal organs. He also described some lightness in his head on deep breathing. At a later stage, he refused solid food and only lived on milk and fruitjuice.

While already this preoccupation about his internal anatomy had a quite irrational note, which he also betrayed in some drawings and scribbings, he gradually expressed more distinctly paranoid ideas : he suspected the food of being poisoned. One day, at home, he "pinched" some honey. When he found that the glass was slightly cracked, he feared that he might have swallowed some glass-splinters and that they might cause internal injuries. He expressed his hatred for women, whom he regarded as dirty and having "lice in their hair". Nevertheless, he clung to his mother and also exempted his sisters from any flaw.

Later, when his inhibitions fell, one could see that this hatred had only covered up a premature erotic interest of a quite crude kind, while, under the polite esteem for his own sisters, jealousy and resentment had been smouldering.

A note of depression was recognizable in his loss of interest in reading and even in good clothes, on which he had set great value previously, also in his occasional ideas of suicide.

In typical ambivalence, he on one hand wanted to withdraw from all contact, but at the same time felt tired and afraid of being alone. For some time he refused to sleep alone, as he would feel that someone was standing beside him. In later stages of his illness, he defined this "someone" as a Muslim maulvi, whom he also heard talking.

He was himself conscious of his increased obstinacy and his spiteful resentment of any criticism.

When we first examined the boy, all these symptoms were still so discrete and fleeting, that one had no reason to diagnose more than a neurotic development or a puberty crisis. He was lean, thin, delicate, with dark rings round his eyes. The liver was slightly enlarged, giving perhaps some real background to his hypochondriac complaints. The limbs were rather loose. We noted some scars on the skull; but neurological examination gave no reason to assume any localized brain-damage. One of the most striking features was the almost ridiculous contrast between the boy's weak, childlike body and his grown-up knowledge and behaviour.

In his helplessness and anxiety, he seemed to be only too glad to have found doctors who had some understanding for his condition and who promised to help. It was arranged that the mother and the 2 younger sisters should stay with the boy in Lucknow, where the maternal grandparents were living, while the father went back to his work in a town of Eastern U.P. As we realized that the company of the compulsive grandmother and the helplessness of the mother might not create ideal surroundings, we offered that the boy could spend a few hours daily with our in-patients, to take part in occupational therapy and recreational activities. As no one seemed to have any proper authority over the boy, the visits, however, were soon stopped. We wrote to the father about our inability to treat the boy or even to control his medication under these circumstances. Almost 2 months after the first consultation, he was again brought by his father, who had taken leave for this purpose. This time, the boy was in a far more severe state of anxiety and excitement. The only hope of helping him consisted in his admission as an in-patient, though he was somewhat below the age-limit we had set for residential treatment. During 6 weeks, we had occasion to observe his manifold psychotic manifestations and to try to stem the flood of

chaos that threatened to swallow him. He went into fits of compulsive shouting, which seemed to form a compromise between his enraged resentment against a world that dared to resist him and a last attempt at keeping the overwhelming tendencies towards aggression, destruction, annihilation, under the discipline of a repetitive rhythm. This superficial order, however, was obviously a poor substitute for the absolute lack of inward restraint. At times it looked, as if ambivalence and negativism could provide some protection against his losing personal identity. As if, consenting willingly to anything that was required or suggested by his surroundings or even by his own body, risked to obliterate his individual distinctness, he had to accompany such acts, as for instance urinating or eating, with violent rhythmical shouts of protest. Inflating himself with air to maximum capacity, he would burst into a loud, explosive : "Ham..." or "Mae..." which seemed to contain the assertion of his whole self-importance, and then taper off into a rhythmical sentence like *e.g.* : "Ham pishab nahin karenge..." *i.e.* : "I shall not urinate", while at the same time allowing an attendant to take him to the bathroom or even urinating in his bed.

These compulsive affirmations of his unique and universal majesty, which also expressed themselves in ruthless destruction and aggressiveness, alternated with phases in which he was entirely a helpless, anxious little child who longed to seek shelter in the safe and cosy lap of a mother figure. One realized that his precocious intellectual development and the boosting of his self-importance had far outstripped his emotional and moral growth. Rigid compulsion seemed to be the only frame still capable of holding the two contrasting tendencies together. When, probably under the influence of the drugs and perhaps also of his growing physical strength, the compulsive structures were dissolved, the manifold sense of omnipotence, associated with rage against anything that dared to resist it, and the childish helplessness and anxiety fell apart and could only manifest themselves alternatively. Gradually, the moments in which he allowed himself to relax to his real status of the weak child, became rarer. Used to regard himself as strong and powerful, he could not bear to see himself weak. Also, all the trouble and harm he had caused to his doctors, nurses and attendants, must have made him feel so guilty with regard to them, that he could no longer accept and trust the same people in the role of understanding and consoling parent figures.

This role of shame and guilt in driving a patient deeper into his psychosis, where he can hide from responsibility, often seems to be a factor that can perpetuate an acute outburst of excitement, which otherwise might never grow into more than an isolated hysterical manifestation. Some of the old indigenous methods of treatment, which in their ceremonies of exorcism combine a kind of public absolution with practice that have the character of physical punishment, but all on a quite "impersonal level", aimed at the possessing ghost and not the patient himself, possibly dispose

of quite powerful means for interrupting vicious circles of this kind. One may wonder, whether certain modern shock-treatments fill a similar function !

To overcome a crisis of this kind in a constructive manner by persisting loving concern and permissiveness, would not only require infinite sacrifices in time, energy and devotion by one therapist, but the well-informed cooperation of a whole staff, in which every member is ready to put his own feelings and concerns behind the need of the patient. This, however, may be more than is humanly possible, particularly if one has to count on attendants who, with a poor salary, have to nourish a big family and who can grant to their own children not even a particle of the attention and care which they would be expected to "waste" on a spoilt, pampered and conceited boy like our patient Onkarnath. Furthermore, a certain firmness and restraint is necessary, as, without any outward boundaries, a patient who lacks inward firmness again will feel threatened by annihilation or indiscriminate merging. In patients of this kind, one actually gets the impression at times, that by their excited behaviour, they want to provoke restraint. We have seen patients who, when they felt threatened by any uncontrollable impulse, would ask their relatives to put on the chains or ropes which were kept ready for them.

As our clinic in Lucknow was primarily meant for voluntary cases that had no need for physical restraint in any form, we were not equipped to deal with the growing excitement of this young patient. Only the weight of the strictly organized, impersonal routine of a big public mental hospital seemed to be heavy enough to hold down the rebellious demonstrations of omnipotence of this spoilt only son. Even when he was taken to a big hospital, after spending some time at home, he tried to prove himself stronger than this order. Finally, however, when the author met him there on a visit about 3 months later, he seemed to have submitted and had arrived at a state of rather childlike helplessness and depression.

One may ask, whether this case really should be classified amongst schizophrenic psychosis. The alternative manifestations of manifold omnipotence and childlike helplessness and depression and the attempts to reconcile these 2 contrasting tendencies in compulsive mechanisms, is rather of typical of manic-depressive psychosis. As, however, at so early an age, even the manic or depressive phases of patients who later prove to be typically "cycloid", are coloured by the natural immaturity of the patient, it is difficult or almost impossible to exclude a genuine hebephrenic component. In Onkarnath, the premorbid personality, described as brooding and withdrawn, furthermore his demonstrations of ambivalence within the psychosis, rather speak against a true manic depressive disorder. So the cycloid element perhaps only forms part of the whole polymorphous character of the prepsychotic and psychotic stages, in which the boy seemed to try out most of the symptoms and syndromes known to clinical psychopathology. Only the further development will allow retrospectively to classify this very early adolescent psychosis definitely.

The role of sibling rivalry has already been demonstrated in the case of Thomas (130). It also figured discretely in the case just demonstrated. Though some of the eldest daughters may have resented the many younger brothers and sisters who did not only steal away the parents attention, but increased their own duties and responsibilities, particular jealousy or rivalry was not reported as a significant factor in any other case.

(11) *Age of the Mother at the Child's Birth.* (Table XII).—The percentage of "young mothers" amongst those whose age at birth of the child was known, only amounts to 10 per cent, *i.e.* considerably less than the general average. This one "young mother" is that of Krishna Kumari (133), who was also our patient. Mothers older than 35, were found in 2 cases, which corresponds to a percentage (20 per cent) 3 times as high as the average for all children. One of these "old mothers", aged 42 at the birth of the child, has been demonstrated in Rajkumari's history (131) as clinging in unhealthy fashion to this youngest child after an early death of her husband.

Another girl, of scheduled caste, was born when her mother, second wife of a very old husband, was aged 41. The girl missed the maternal pampering when finding less concern at her in-laws' home.

(12) *Complications of Pregnancy and Delivery* (Table XIII).—The fact that the columns for complications of pregnancy and delivery are both blank in this group, need not necessarily mean that no such disturbances had occurred. As we mentioned earlier, the more advanced age and the often acute, serious trouble for which these adolescents were brought, were often the reason, why information about infancy was not complete. Also, as most of the patients came from big families and some from the uneducated class, even the mothers, if we had a chance of interviewing them at all, did not always remember in detail, what course the pregnancy and delivery of each individual child had taken.

In 6 of the 11 cases, amongst them the one case with slight neurological symptoms, (Shanti 129) we have positive information that pregnancy as well as delivery passed without complication. In the remaining 5 cases, we can only hopefully suppose that, if any very extraordinary difficulties had occurred, the parents would have remembered and told us.

(13) *The Period of Breastfeeding* (Table XIV).—The same lack of information about the early infancy of the patients in this group prevents us from making any valid investigation with regard to the role of breastfeeding for the development of later psychotic manifestations. For 8 of the adolescents, information is lacking. In the 3 cases for which the period of breastfeeding is known, it did not exceed a length of 2 years.

While, thus, information about the early upbringing or the patients themselves is very scarce, we were able to make some observations on the attitude which two of the married girls displayed with regard to the breastfeeding of their babies. Their

full case histories will be given later ; in this connection, we shall only sum up the relevant features, which may throw some light on the attitude of very young mothers :

A Sikh girl (138) was followed by us in intervals from the time of the first excitement, just after marriage, to the period after birth of her first child 10 months later. While her symptoms had first struck one as mere hysterical demonstrations, she later presented typical hebephrenic features. When her first child, a boy, was born, she liked to display him as a matter of pride, but refused to take care of him. We once observed, how the accompanying women held the baby to her breasts, while she was not in the slightest concerned about what was going on.

One other girl, Hindu Shudra (139), gave birth to a daughter at the age of about $15\frac{1}{2}$, after having been married since the age of 13. When the baby was about 16 months old, the young mother still continued to breastfeed her. During one interview, however, she expressed that she very much resented having to give her milk, as the baby at times bit her breasts. At the same time she told us that she herself had become like a baby, unable to wait for her food. While this patient still was able to distinguish between her role as the mother and her own childish tendencies, other psychotic mothers amongst our adult patients seemed to be completely confused about their situation. They would behave like small, helpless children themselves and even try to suck their own breasts.

(14) *Toilet Training*.—If our information about toilet training was already rudimentary in the other groups, in which at least some of the children had not grown very far from infancy, we naturally cannot expect any data in this respect, where patients of the oldest age-groups are concerned.

Symptoms involving excretory functions were only reported in 2 cases and observed by us in one further case. Again, however, as we have seen it in the psychotic children, these were not characterized by a genuine lack of control, but rather by deliberate misuse of these functions ; possibly at times they may have been the result of confusion.

One girl would “urinate in odd places”. Rajkumari (131) whom we have already presented, took to playing with her faeces. Onkarnath (134) at times would urinate in his bed with obvious spiteful satisfaction, while in our clinic.

Tenacious constipation can often be one of the physical signs accompanying catatonic withdrawal, fitting into the total picture of closing oneself up against any communication with the “outside” world. It was mentioned in 3 of the 11 patients in this group.

(15) *Early Neglect and Separation*.—A typical situation of early neglect or separation does not seem to have taken place in the infancy of any of the patients in this

group. Again, however, our information is scanty. The case in which some maternal neglect may have been most likely, is that of Thomas (130), whose mother worked as a teacher and who was sent to boarding-school very early and never enjoyed much attention from either of his parents.

None of the children were explicitly "unwanted". Krishna Kumari's mother (133) resented all pregnancies after the third ; but the patient herself, as the first child, was welcome.

(16) *Parental Attitudes* (Graph VII) .—The graph illustrating parental attitudes for the group of psychotic adolescents bears some similarity with that for the psychotic children, insofar as the columns at both extremes, *i.e.* that for "expecting too much" and for "rejection" are blank. While, however, the group of infantile psychosis was characterized by a lack of normal acceptance on the part of both parents, 27·3 per cent of the psychotic adolescents appeared to have grown up under fairly normal parental concern. Furthermore, divergent parental attitudes, which we found prevalent for the group of infantile psychosis, hardly play any role for the psychotic adolescents. Inconsistent parental attitudes, on the other hand, while lacking in the group of infantile psychosis, are just as frequent as pampering and neglect (18·2 per cent) in the group of adolescent psychosis.

We have already tried to show, in the introductory paragraphs to this chapter, that parental attitude and family atmosphere may not quite play the same role for autistic children and for psychotic adolescents : for the child with very early disturbances, the unaccepting or stifling family-climate forms the world into which he is born from the safety of the womb ; for the child who breaks down at the time of puberty, relatively adequate parental concern may represent the warm and comfortable nest from which he is rushed out into a strange, possibly hostile and demanding world, as for instance 4 of the girls in our group through their early marriage.

Amongst the cases already presented, we have had examples of practically all possible parental attitudes : The pampered only son Onkarnath (134) ; Lalli (132) and Krishna Kumari (133) accepted within the limits which the mental illness of the former's father and the latter's mother allowed ; the neglected Thomas (130) and Shanti (129), exposed to the inconsistent attitudes, wavering between extreme permissiveness and harsh beating and rejection, not only by her own parents, but by a big joint family. Rajkumari (131) who has been listed in the column for "divided parents", was completely delivered to the mother's paranoid overanxiousness after the pampering father had died.

An example of overanxiousness on the part of both parents is still to be given :

(135) *Ali* was the second of 3 sons from the second marriage of a Muslim zamindar. The father, a sensitive, perfectionistic intellectual, had a foreign degree and was

spending his time mostly in historical studies. He was worried about the shrinking of his income from a quite fabulous size to a still quite handsome sum. In his overanxiousness about his son, he would claim plenty of the doctor's time, but hardly ever keep to the advice given, as any treatment suggested appeared to him either too troublesome, too risky or too compromising for the family reputation.

Ali's mother, the second wife belonging to a distinguished family, was described as fashionable and domineering. Her overanxious, possessive attitude was only revealed to us in its true colours, as the boy's illness progressed. One daughter from the father's first marriage lived with the relatives of the deceased mother. The 3 sons of the second union were born at intervals of 2 years. The elder as well as the younger brother were described as intelligent.

Again, as we never had an opportunity of meeting the mother, we know practically nothing about the boy's early infancy. He suffered from typhoid at the age of 7-8 and went through some of the minor childhood diseases. Once he fractured his right arm.

Since early childhood, he had been rather reserved and dignified and very particular about his food. Though he was intelligent, his achievements in school seem to have lacked regularity. One year he failed, but again stood first next year. At the age of 15, he had reached 8th class. In his spare time, he took interest in drawing and painting.

The setback in his educational career was related to a first phase of "nervous trouble" at the age of 11 : He would go into sudden fits of weeping, when anything went against him. He got over this disturbance at the age of 13 and did not present any unusual behaviour for the next 2 years.

At the age of 15, however, one month before we had occasion to examine him, he complained of physical weakness and lack of concentration. He became quiet and withdrawn and often kept lying on his bed.

The tall, thin, asthenic boy was little developed as far as secondary sex characteristics were concerned, but had obviously gone through an intensive phase of growth in length recently. His chest showed signs either of a congenital deformation or of early rickets. Apart from a slight asymmetry of facial innervation, no neurological signs were found. His hands and feet were cold, as if circulation were being kept from reaching them. He looked depressed, anxious, restless. His careless gait betrayed hopelessness. He hardly talked, but kept biting his lips and playing with his fingers in a tense, uneasy way. It was quite obvious that he was on the verge of complete catatonic withdrawal. The only means of voluntary expression left, seemed to be his drawing. When given paper

and pencil, he drew a very alive tree with a sturdy trunk, but rather vague foliage. When asked to draw his own portrait, he produced the face of an elderly man. A picture of his free choice represented the traffic on a bridge. One could easily recognize his remarkable skill and his sensitive perception ; the contents of the pictures, however, did not betray much of his tension, possibly because his technical ability had been routinized, so that it could be used without much inner engagement.

Though we warned the father about the seriousness of the boy's condition and urgently advised admission to the clinic for thorough treatment, the family hesitated. As the summer heat was approaching, they decided to take him to a hill-station. A few weeks later, the father reported that the boy had first refused to move from Lucknow. Finally he was taken to the hills by car under false pretence. Even then, he was extremely anxious on the way and refused to continue the journey, until some hakeem was called to reassure him. Once he was up in the hill resort, he became more and more quiet. He stopped speaking and eating and finally had to be tube-fed. We suggested to the father, who had come for our further advice, that, instead of urging the boy to eat, they should simply leave some food with him, as such patients sometimes will eat when they are alone and when the food is not explicitly offered or forced on them. To this, we got the reply that a procedure of this kind could not even be thought of, as the mother was constantly hovering over the sick boy, never allowing him to remain alone even for a minute ! No one came back to report about the boy and we do not know, whether any expert treatment was finally accepted in some other place.

An example in which parental attitude did not seem to present any significant deviation, but in which the contrast with the rejecting atmosphere at the in-laws' house seemed to have precipitated the breakdown, has already been given in Lalli's case-history (132). Two other girls had to face rejection by the in-laws, though probably only as a consequence of their abnormal behaviour, while one further girl, the one who had lost both her parents, did not complain about the in-laws, but was disappointed by her husband and probably overwhelmed by the awakening of sexual interests. The histories of these 3 girls will be used as illustrations for problems of adolescence in a later paragraph.

(17) *Physical Defects* (Table XVI).—Six of the 11 adolescents presented some physical trouble. The only case with discrete signs of organic brain-damage, Shanti (129), has already been mentioned. Dysplastic signs, though probably due to rickets and not to a congenital malformation, were found in Ali (135).

Of the 4 cases in which some recent physical trouble accompanied the psychosis, we have seen Onkarnath (134), whose liver was enlarged, and Krishna Kumari (133), who showed signs of slight goiter. In one other girl we noted purulent discharge from

one ear, general weakness and malnutrition and a tetanic hyperexcitability of nerves and muscles. While Krishna Kumari's thyroid gland was only enlarged, but did not show any signs of hyper-or dysfunction, another girl presented fairly typical signs of thyreotoxicosis :

- (136) *Promod Kumari* was the 4th of 10 children of a Brahmin family. The father, a bank clerk with a salary of Rs. 150, had every reason to worry about this big family, but seemed to be rather helpless about improving the situation in any way. The mother appeared to be more intelligent than the father. But she preferred to go out and talk to the neighbours instead of attending to her housework, which the older daughters were expected to do meanwhile.

Three of the 10 children had died, one soon after birth, one of infantile liver at the age of 2, and one of small-pox at the age of 4. Of the 6 surviving siblings, one brother and one sister were older, 2 brothers and 2 sisters younger than Promod Kumari. The youngest brother was only aged 2 years, when we met the family.

Again we know practically nothing about the girl's infancy. She was described to have always been gentle, simple and rather quiet. At the age of 7 to 8, on falling from a verandah, she sustained a head-injury. Otherwise she had always been healthy. Menstruation had started at the age of 13 to 14.

In school, she was rather hard of understanding. The sister born one year after her, had caught up with her and went to the same class. After terminating 8th class, the girl gave up her studies. She seemed to have felt somewhat ambivalent about this step. On one hand, she had always had difficulty in learning and she resented comparison with her younger sister, while she took a natural interest in housework, particularly in cleaning and tidying up. On the other hand, just at about the time when she left school, the eldest sister got married and went to her in-laws', so that more work fell on Promod Kumari's shoulders. The mother seems to have limited herself to criticizing and ordering about rather than taking an active share in work. As far as we know, the acute symptoms : confusion, shouting the names of Gods, aggressiveness when obstructed, refusal of food, started during this sister's wedding when the girl became a victim of the teasing and practical jokes customary on such occasions.

We did not actually see the girl during this psychotic phase, but only after she had been treated with tranquilizers and a series of electro-shocks at Medical College. When she was brought to us, 10 months after this acute disturbance, the family were concerned, because she still was irritable and at times went into fits of abusing. She had also developed some fear of dirt and compulsive habits. The girl herself knew that "her mind had gone bad" and was very much ashamed of her phase of excitement. She complained of irritability and nervousness,

in particular a great sensitivity to noise, which made her wish to withdraw to a quiet place.

Physically, we noted the swelling of the thyroid, a rapid pulse, a slightly increased blood-pressure, tremor of the hands and deficient convergence of the eyeballs, all signs which pointed, together with the irritability and excessive sensitivity, to a disturbed function of the enlarged thyroid gland. In contrast to the rather plump figure, the girl's hands were long and slim and the unusually soft palms were criss-crossed by a network of finest lines without any well defined main design.

She described that, since she had recovered from the psychotic excitement, she had got into compulsive habits of cleaning and washing. She would take her bath for a long time and also insist on cleaning and bathing the younger siblings, whenever she suspected any dirt on them. With regard to food, she showed no particular suspicion of contamination. We noted, however, that she had very high ideals of moral purity. These ideals had, of course, been offended by her psychotic outburst. It looked, as if not only the compulsive pattern, but probably also the hormonal disorder were in the service of keeping down the aggressive, resentful tendencies, so that they should not break out in further humiliating scenes. Unfortunately, we do not know, whether the hyperthyreotic signs were already noted during the psychotic phase. If they were, one might of course doubt the diagnosis of a genuine schizophrenia and rather talk of a "hyper-or dys-thyreotic psychosis". From a total psychosomatic point of view, we need not be so much concerned about the primary or secondary nature of one or the other disorder. The main fact seems to be that the girl was narrowed inner possibilities not only by the excessive demands which the mother's laziness and the elder sister's marriage put on her, but also by her own strict conscience. Furthermore, being one of many children of a careless mother, she probably had never received a sufficient store of maternal warmth and care, which could have supported her and rendered her inwardly ready for the premature load of work and responsibility.

The psychotic outburst seems to have happened, when teasing and criticism flew like sparks into the accumulated tension. This "solution" was not tolerable for the girl's delicate conscience in the long run. The rather drastic treatment may have paved the way back to a state in which she could dispose of the threatening impulses in a less shocking and compromising manner : partly through repression into the physical sphere, where the "swallowed" anger so-to-speak got stuck in her throat, partly tied down by the compulsive habits, which at the same time may have dispensed her from part of the housework without risking the reproach of being "lazy". Furthermore, the superstitions current in family and neighbourhood provided satisfactory excuses for the fits of temper which still overtook her occasionally : It was believed that the goiter was due to her having looked at a cat and that the manifestations of anger were the result of the "hot medicines" which she had been given against this swelling in her throat !

(18) *Former Illnesses* (Table XVII).—If already the list of physical defects stated on examination is fairly scanty for this group, the collection of illnesses through which the psychotic adolescents had been passing previously, is even less impressive. Only typhoid, claiming 3 victims, shows a considerable frequency, which, however, still remains behind that in the neurotic group. The relative freedom from infectious diseases, which seems to characterize the young people in this group, is all the more remarkable, as, at least during their early age, they cannot have profited yet as intensively of the modern prophylactic measures as smaller children. Also, their coming mostly from big families and, at least partly, from the lower social strata, might have exposed them to infections of various kinds.

Unless one assumes that, like certain adult chronic schizophrenics, even young people with a disposition to developing psychotic manifestations have a quite particular resistance against physical illness, one may again ask, whether perhaps children of this type, if actually attacked by a severe infection, have less chance of surviving. Both questions may, however, be quite idle in view of the small number of patients observed and would only have their validity, if investigations on a wider material should show up similar conditions.

(19) *Education*.—As none of the children in this group had been handicapped in any way since early childhood, one need not expect any significant correlation between the psychosis and the educational level attained at the moment of its outbreak. The scattering with regard to school-standards, which does not quite correspond to the fact that all patients were aged between 13 and 16, is far more due to social factors than to any variations in intelligence (Table 26).

Table 26

Educational Standard of Psychotic Adolescents.

	Male	Female	Total
No formal education	—	1	1
Education at home	—	2	2
1st-4th class below age	—	2	2 (left school at that standard)
4th-8th class according to age	—	3	3
4th-8th class below age	2	—	2
9th-10th class above age	1	—	1

The 2 boys who manifested their first mental symptoms early and later took up school again, were in classes slightly below their age. The third one, Onkarnath,

(134), at the time when he had to stop school because of his psychosis, had reached a level beyond his age.

Amongst the girls, Shanti (129), had had practically no formal education. Two girls had been taught at home. The two who are noted as having reached classes "below age" at primary level, were given no further opportunities to learn beyond 2-3 years, though they were intelligent. 3 girls had terminated their education after 7th or 8th class at a level corresponding to their age. It may be interesting to note that none of the girls who went into psychotic behaviour at the age of puberty was of the highly educated, emancipated type, while all 3 boys did not only belong to educated families, but themselves were engaged in courses leading to higher studies.

A threatening situation in connection with exams had played a role in Onkarnath's (134) case. The ambitious, intellectually precocious boy was disappointed about not reaching the position he had aspired for and got into conflict about helping a neighbour to cheat. Ali (135) may have been worried about his failure in one class, while Thomas (130), who had also failed in one exam., had to stand the teasing of his brothers and later of his classmates about his first phase of illness. Whereas Krishna Kumari (133) resented having to break off her schooling after a failure in 7th class, Promod Kumari (136) did not seem to mind so much giving up school, as rather the load of housework that was put on her instead of further education.

(20) *Problems of Adolescence.*—Problems of adolescence can naturally be expected to have played a role in all the patients of this group, which is characterized by the onset of emotional disturbances during puberty. We have earlier shown that one may have to distinguish between conflicts that are created by the biological happenings of puberty itself : the rise of sexual interest, new forces of aggression and self-assertion, and others that are merely a consequence of the particular expectations and responsibilities which the family or a wider society impose on a young person at this age.

The 3 boys in our group did not have to face any particular outward strain, except that given by school-life and the ill-advised attitudes of their parents, which, however, were no particular features of the puberty period. While the closed facade of Ali (135) did not let one guess any of his conflicts, Thomas (130) and Onkarnath (134) showed signs of the rising of sexual interests and aggressive forces. In the latter, during the worst phases of psychotic excitement, these tendencies came out quite openly in the form of destruction, aggression and obscene talk. Thomas (130) first experienced the "bad things" which he could not recognize as belonging to himself, in the form of hallucinated figures who tried to tempt him : during the later phase, it seems that he found prototypes of such objectionable behaviour in his new class mates.

While thus, for at least 2 of the boys, the problem may have consisted in their experiencing new forces for which life did not provide any legitimate outlet yet, and which their undeveloped bodies and minds had not learned to contain, some of the girls,

on the contrary, were precipitated into situations by which sexual interest, still lying dormant, was roused prematurely and in which, furthermore, they had to grow into the biological functions of married life and motherhood before they were ready for them.

The one married girl already presented, Lalli (132), was sent back by her in-laws as useless, probably before she even had joined her husband. The 3 other cases to which we could add many similar ones from the age group 16 to 20, are to be summed up now :

- (137) *Indrawati* was seen 2 weeks after marriage, which at the same time marked the acute onset of psychotic symptoms. Her father, a hardworking farmer of scheduled caste in a village of U.P., had died of some abdominal trouble, when the girl was aged 12 years. Two years later, the mother also died. No mental illness was known of in the family.

Indrawati was the first girl born after 2 sons. The eldest brother, 11 years her senior, educated up to High School, was a clerk with a meagre salary. He was married, but had no children yet. The next brother, aged 20, had not learned anything and was not engaged in any work. Younger than Indrawati, were a brother aged 11 and a sister aged 8.

Again we know nothing about the girl's early upbringing. Already before her illness, she often lost her temper, in particular when anyone disturbed her compulsive order and her rites of cleaning.

She had only been educated up to 3rd primary class. Towards the end of her 16th year, she was married. As the two families knew each other and the two young people also had a mutual liking, the marriage was arranged in spite of a very modest dowry. It seems that the girl went to stay with the in-laws immediately after the marriage ceremonies.

Before long, she experienced a great disappointment : her husband told her that he had resigned from his job and that he would go to live at a hostel, so as to study for M.A. This meant that the girl would have to stay with her parents-in-law without the protection and pleasure which the husband would have provided. Shortly after hearing this shocking piece of news, she went into unmotivated weeping, laughing, singing and irrelevant talking. She was forgetful and distracted and got angry, when opposed. She hinted that she had been poisoned. In her confusion, she took the ornaments of the sister-in-law and decorated herself with them.

The small, rather plump girl still looked very childlike. She complained of anxiety, of a burning sensation, pain in her body, palpitations and lack of appetite. She told us in detail, how a cousin-brother, with whom she was on bad terms, had "poisoned" her by offering her some food. It was not clear, why he had to play the role of the scapegoat.

Somewhat more realistically, when she had already calmed down under suitable medication, she told us that, when the excitement broke out, she had already had intercourse with her husband. On one hand she felt pleasure, but on the other hand, having always been compulsively clean and prim, she could not help finding this new experience "dirty". She probably felt that, in the husband's absence, she would not be able to cope with the newly roused desire which, even while she was still with him, threatened to overwhelm her. She felt in conflict between her wish to spend as much time as possible in privacy with her husband and her duty of pleasing the in-laws by showing herself modest and decorous.

All these conflicting tendencies, which threatened to break down her ideal-image of herself and her compulsive adjustment to life, could no longer be reconciled, and she went into confusion. When her behaviour began to appear strange, the in-laws sent her home.

As her brothers seemed to be satisfied with the first temporary improvement through the drugs prescribed by us, she was not brought back after the second consultation, and we do not know, whether later she was able to adjust to life with the in-laws.

This sudden bursting of all dams of restraint and accustomed modesty by the newly and prematurely roused sexual instincts, is a phenomenon we have noted in several of the older adolescents, particularly in girls. From one family, two sisters were brought successively, with quite similar manifold symptomatology, both immediately after marriage. Both had taken to sex life with unleashed passion, to the general disgust and indignation of the in-laws, who had expected modestly blushing brides! After thorough treatment, both made a good adjustment. We met one of them again casually a few years later, as a quite well-behaved, dignified mother of two children. In other cases, the outbreak of excitement after marriage only marks the first sign of an inability to adjust to any new situation. Further psychotic phases follow at the start of the first pregnancy and possibly again after delivery. A case of this kind, deteriorating rapidly in spite of all therapeutic measures, is that of Lado :

(138) This Sikh girl, *Lado*, daughter of a businessman from a small town in U.P., was first seen by us at the age of 15, shortly after her marriage.

Her father was somewhat short-tempered, but on the whole rather submissive, dominated by his aggressive, quarrelsome wife.

Lado again was the eldest daughter. One elder brother had already joined the father in his business ; another brother had died at the age of 3. Lado was followed by 2 brothers, then a sister, then 2 more brothers, the youngest one only aged $1\frac{1}{2}$ years, when she got married. So, finally, she was the second of 7 surviving siblings.

Her early development was described as "normal", except for the fact that she started talking late. She remained rather shy up to puberty age. She went to school up to 7th class.

Menstruation started at the age of 13. At 14, she was married to a 25-year old Sikh businessman. This young man, who later proved to be admirably patient and loyal with regard to his sick wife, had failed in his High School exam, having never been interested in studies. He hinted that, before his marriage, he had had to take some injections, probably against syphilis. The husband as well as his parents at first treated the young girl very kindly. It seems that the predominantly hysterical manifestations, which the girl presented, when we first saw her, about 3 months after marriage, had been released by the shocking experience of first sexual intercourse, for which no one had prepared her. She was brought to us in a fit of shouting, crying, beating, kicking, rolling on the ground. The parents, to whom she had been sent back, reported that at home, apart from these fits of excitement, she had been urinating in odd places, refusing her food for several days and not finding any sleep at night.

Though already at that time, the girl showed some maniform ideas of greatness, the demonstrativeness of her behaviour, her relatively prompt reaction to treatment, the good emotional contact and her youthfulness, which somehow made the slightly hebephrenic features look like mere signs of "the awkward age", still allowed to classify her as a case of hysterical neurosis. After about 5 weeks of medication with tranquilizers, sedatives and vitamins on an out-patient basis, the relatives declared themselves satisfied with the improvement. She was sent back to the in-laws, where now she began to take pleasure in the physical contact with the husband.

Three months after we had started our treatment, *i.e.* about 6 months after marriage, she became pregnant. We saw her again during the first months of this pregnancy. She looked weak, pale and anaemic, rather depressed and careless, but reacted well to mild treatment. After birth of the child, a healthy boy, depression and lack of interest became more obvious. She refused to care for the child and looked utterly exhausted. About 6 months after the delivery, she went into a state of maniform excitement. She now expressed definite ideas of greatness and omnipotence. She would wander round in the doctor's office, pointing to each article and maintaining that either it belonged to her or that she had made it. Of course she also had written all the books on the shelves. She was going to study and become a famous doctor. The whole world belonged to her and had to provide for the satisfaction of her desires, while she was not in the least inclined to accept any of her responsibilities and duties. Whereas the husband still showed affection and loyalty, his parents had by that time lost patience with their useless daughter-in-law. The girl's mother, on the other hand, who had always been against this marriage, seemed to triumph and to stir

the discord with the in-laws. It looked more and more as if, in her domineering possessiveness, she had been out to ruin the success of her daughter's marriage right from the start. The girl herself was in dilemma : on one hand she was disgusted with her mother's fussy clinging ; on the other hand she did not dare to break loose from her grip, as she did not feel sure of the in-laws' interest. This situation already had announced itself discretely, when we first saw the girl soon after marriage. During the later stages, the problem became more and more obvious.

As the husband implored us to do all we could to save the girl from having to be sent to a mental hospital, we consented to give her a course of electro-shock on an out-patient basis. Temporarily, she seemed to improve. She even began to look quite charming and to show some real affection for her husband, whose patience she had tried so hard with scenes of biting, kicking and scratching.

A few months later, however, the dejected husband reported that she had fallen back into her state of excitement. As by that time, no one in the family was ready any longer to cooperate in treatment, the only way he could see was to admit her at a closed mental hospital, for which purpose we gave the necessary report and recommendation.

- (139) *Somawati* should perhaps already figure amongst the older adolescents, as the greater part of the 16 months during which we followed her fell into the time after she had reached the age of 16. As, however, her marriage was performed at the age of 13 and the first signs of a mental disturbance appeared one year later, she seems a fitting example to illustrate the problems of early marriage.

Somawati's father, a Shudra labourer in the building-trade, had spent all his life in a village. He died at a very high age, according to the patient at 93, two weeks after the daughter had joined her husband. From a first marriage, the father had 5 children. Our patient's mother, the second wife, was described as a simple, but somewhat short-tempered village woman. Of her 10 children, only 6 survived. Amongst these 6, *Somawati* was the 5th and the only daughter. She grew up in traditional, orthodox village style in the security of a joint family. As the only surviving daughter, she got much love and attention.

From childhood, she was shy, withdrawn and sensitive. She only visited school for 2 years, but had some good knowledge of the old Indian epics. Apart from some ear-trouble, she never was seriously ill.

At the age of 13, she was married. She was sent to her in-laws a few months later, after she had had her menstruation only twice. Knowing nothing about the duties of a wife, she was shocked by the bleeding and pain during first intercourse. Her in-laws were rather backward village people, who constantly found

fault with the delicate girl. The husband, good-natured, but less differentiated and sensitive than the girl, worked as a salesman in the city and was the main supporter of his family.

The first signs of confusion seem to have occurred when, only two weeks after joining her husband, when she had gained no secure foothold yet in her new surroundings, she had to attend her old father's funeral. At that time, she was shocked by a horrible dream : She saw the women cleaning utensils after a feast. Then suddenly their heads were cut off and placed on the dishes. She began to get sleepless and at times laughed and talked to herself or went into abusing. This first phase apparently subsided quickly, and it was only about 1½ years later, when she had already given birth to her first baby, that we had occasion to examine her. At that time, her husband reported that, apart from the symptoms already noted earlier she went into fits of beating and biting. She was often heard talking and laughing to herself. What she spoke to others, often did not seem to make sense. Recently she had been more depressed than excited.

The small, delicate, flowerlike girl, —one could hardly call her a woman, though she was already a mother !—complained about pain in body and head, lack of sleep and appetite, general weakness and depression. There was something dreamy and resigned about her. In answering questions, she often went autistically past the issue. Sometimes one could notice in her talk superficial associations by sound or rhyme. It was only later, when we knew her better, and when she had become more confident, that we began to understand some of her "private meanings". Physically, she was emaciated and undernourished. We found purulent discharge from one ear and a hyperexcitable nervous system. During 10 visits, distributed over 3 months, we gradually gained quite a bit of insight into the inner life of this delicate, sensitive girl. There seemed to be a pathetic contrast between the refinement of an innermost spirit and the inadequate means it had been given for expressing itself in the primitive surroundings into which she had been born.

She told us that, even while pregnant, she had been quite ignorant of the biological facts of motherhood. She kept wondering, how God had put the baby inside her body. She thought that her stomach would have to be cut open in order to give it birth. Then she mixed up the delivery of her own child with the birth of Sri Krishna. Some other time, she seemed to identify herself with Sita. Once one had realized that she lived very much in these old myths, one could understand many of the remarks which, at first sight, seemed "irrelevant". She also told us about the voice of Bhagwan, which advised her what to do and what not to do, by this obviously meaning her own conscience. After she had recovered from this phase, which, at the time we saw her, could best be characterized as a mild form of depressive catatonia, she seems to have done well for about one year. Then, after returning from a visit at her own home, where probably she had once

again experienced all the former pampering care and love, she again became depressed, anxious and withdrawn. The husband maintained that the relapse had been precipitated by fear of a ghost, when she went to fetch water in the dark.

It was at that time, now aged 17, that she complained about the baby's habit of biting her breasts while being suckled and that she mentioned her own childish inability to postpone the gratification of her desires, *e.g.* of her hunger. When we remarked that sometimes she probably wished that she could be in her child's place, sitting in the mother's lap, she answered in her dreamy voice, with a resigned sigh : "Whose lap is there, where one could sit ?"

This remark of the simple village girl who, however, seemed to be too delicate for her surroundings, perhaps betrays the same longing for someone who could give full understanding and shelter to all the unaccepted sensitivity, which we found in far more sophisticated form in the remark of the brilliant young scholar who called himself an "intoxicated" and "theoretical" person, "whom there should be someone to recognize".

We shall never know, whether these young people, in particular these married girls, who somehow seemed to be like prematurely plucked flowers or fruit, robbed of their chances for complete ripening, could have had a better opportunity of growing up harmoniously, if they had been allowed the protection of their parents' homes a bit longer or whether, after all, an innate weakness made them quite generally unfit to step out into a life of "usefulness" and responsibility. Human life allows no experiments ; a situation once entered into, cannot be reversed so as to see, how matters would have turned out, "if..." or "if not..." ! Prevention, reflection before taking a step, honest attempts to know the needs and capacities of a young person before rushing him or her into any new situation, may therefore be more helpful than even the most expert treatment, once the break with reality has happened. Counselling services for students, for vocational guidance and for young marriage candidates could therefore play an important role in preventing at least a few tragedies of this kind.

(21) *Interests*.—Only 7 of the patients in this group had indicated any particular interest.

Of the boys, one set great value on fine clothes, but at the same time, as also one other boy, was interested in reading. Two enjoyed manual occupations and one was fond of music.

Of the girls, one took interest in games and sports, 2 liked music and dancing, 2 manual activities, mainly in the household, and one only engaged in intellectual pursuits.

The list of interests may be more typical for the social background of the adolescents and for the opportunities it provided than for their real inclinations.

(22) *Number of Visits and Possibilities of Treatment* (Graphs VIII and IX).—The severity of the disturbances and the often acute onset, the scarcity of other treatment facilities, unless one wanted to resort to a closed mental hospital, brought with it a surprising persistence in treatment of most of the relatives of this group of patients.

Graph VIII shows that only one of the girls [Rajkumari (131), whose mother jealously guarded her !] did not return after a first visit. Even the ones who were only brought for 2 or 3 consultations, as one will see from the graph for "results" (Graph IX), had registered some degree of improvement and were not shown to us again, as the relatives apparently were satisfied with the possibly temporary result.

On comparing the 2 graphs, one will note that, for the girls, the results were relatively more satisfactory than for the boys. Two of the boys, though all 3 of them showed considerable persistence, two even enjoying the benefits of in-patient treatment, could not be significantly influenced by what we had to offer. One will remember that Ali's (135) parents did not give us a chance of applying any consistent treatment, while Onkarnath (134) in spite of all our efforts, finally had to be transferred to a closed mental hospital.

Amongst the girls, on the other hand, except for the one case who did not return, all benefited to some degree, two even to the point of "social remission". We know, however, that in at least two of them, Lado (138) and Somawati (139), the success was temporary. While in one a second treatment was again helpful within a short time, the other one, Lado (138), finally had to be recommended for a closed mental hospital.

The difference in therapeutic results between the male and female patients probably reflects the contrast in their social background : While all the boys came from educated families and themselves were advancing towards higher studies, the girls were not only, at least some of them, of lower social status, but from families where education for girls was not encouraged and where life mostly moved on the level of mere fulfilment of vital needs, without concern for any cultural refinement.

Just as a complicated precision instrument may be more difficult to repair than a rough-hewn tool, once it is out of order, human equilibrium may perhaps also have its variations in subtlety and precision. Where much has been gained, much can be lost, and restitution to the previous differentiated level may be troublesome or even impossible. Where individual differentiation has not advanced very far, where a human being is still close to empathic-symbiotic patterns of living, disruption into psychotic chaos may not lead so far away from the "normal level", and reintegration may be relatively simple. The case with which some of our patients from less educated or even illiterate background seem to have disintegrated into psychosis and then reconstituted themselves without much sign of any permanent damage, at times reminded one of the "kachha huts" of the Indian plains : quickly built, easily collapsing, when storms and

floods come over them, but rising out of the mud again as soon as the ground is dry and the sky clear !

Cases with symptoms similar to those which, in this Indian setting, we had to treat on an out-patient basis, would probably have been admitted at a closed mental hospital in the West. Not only the families might not have tolerated the patients' excitement, but the neighbours would probably have run for the police ! This lack of tolerance, however, may be one of the factors that drives a patient deeper into his psychotic disorder and removes him further from contact. For a person used to the symbiotic support of the family, being separated from it and thrown into the unaccustomed surroundings of a hospital, may well break his last links with reality and increase his confusion. On the other hand, in certain cases, change of surroundings can be very beneficial. On the whole, however, in planning future psychiatric services, one might do good to provide either opportunities for out-patient treatment in rural areas or then residential services with "family-quarters", where the patient can at least partly remain in the company of his relatives, and the social worker can at the same time have a chance of studying and possibly influencing any harmful family patterns.

The psychopharmaca which have been developed during the last 10 years, allow far more than this was possible formerly, to undertake out-patient treatment even of severely excited cases. In the West, under these new conditions, the public has to be educated again into accepting its mental patients and convalescents in its midst instead of banishing them behind the high walls of closed hospitals. India has the advantage of being able to found this stage in the evolution of psychiatric care on the readymade base of a still originally persisting tolerance and acceptance of all human phenomena. Even if this very tolerance implies of much indolence, carelessness and perhaps even callousness, the further development of psychiatric services should take care not to move away from it, but to recognize it as a valuable help for building up new methods and elaborating others that are being tried out in the West : such as day-hospitals, sheltered workshops ; therapeutic groups, not only for the patients, but also for their relatives ; well organized social services for home visits, contact with employers or, for children, with teachers.

For the more differentiated patients, however, for whom the aim is not necessarily to be fitted back into the irritating surroundings, but, on the contrary, to grow out of them into individual responsibility, there should be opportunities for prolonged specialized psychotherapy, possibly also on an out-patient basis, or then in small private institutions that can take account of the refined needs of people of this kind.

In particular, however, special services should be available for psychotic adolescents below the age of 16. Their needs are different from these of older patients. Parents who apprehend sending a mentally disturbed adolescent to a big mental hospital, may not be so far off the mark, if they fear the risk that the young person might "pick up" a few more symptoms, if allowed to mix with more advanced cases !

If separate institutions cannot be thought of at this stage, there should at least be separate wards and recreational arrangements for the youngest patients.

IV. *Juvenile Delinquency.*

1. *General Remarks.*

By now, all the children examined have been presented within the various diagnostic categories, either in detail as examples for one or the other feature, or then figuring as mere "numbers" in the different Tables and Graphs.

A publication on child psychiatry, however, would not be complete, unless something were said in it about the problem of juvenile delinquency. In the various chapters, we have occasionally pointed out that some particular case had been regarded as "delinquent" or "potentially delinquent". Some of these case-histories have already been quoted ; others were reserved for this special chapter.

As the case-histories of children with delinquent features observed by the author during her activity in Lucknow have already been utilized for a special study on juvenile delinquency [Hoch (18)], we are going to follow more or less the order of that publication, though it slightly deviates from the sequence in which we have arranged the material in the preceding chapters of this present work.

The separate presentation of this small number of "delinquent" and "potentially delinquent" children and adolescents, though none of them had been officially apprehended as "offenders" yet, has its particular importance : Here in India, not only with regard to juvenile delinquency, but criminality in general, one gets the impression that, far more than in Western countries, unfavourable outward circumstances : economic misery, destitution, possibly also the influence of bad examples in social groups with distorted moral standards, *e.g.* amongst the criminal tribes, are amongst the factors that make a person deviate from a lawful course of life. It is therefore natural that judiciary and correctional services should first have developed with a view towards accommodating and rehabilitating criminals and juvenile delinquents that have become the victims of such external factors and that, up to now, we do not find much provision yet for the treatment of those offenders in whom less gross influences, but perhaps quite subtle neurotic conflicts, have distorted social adaptation. It is unlikely that cases of this latter kind have not existed up to now. They seem, however, to have had a sufficient field of action within the frame of the joint family and small, closed communities, thus remaining sheltered not only from taking a damaging effect on a wider society, but also from being apprehended and punished by official authorities. With the increasing disintegration of the family structure, we have to expect that more of the consequences of such socially undesirable behaviour will leak out into society. On one hand, more of a person's, particularly also a child's and adolescent's life will be spent outside the family, so that any delinquent tendencies will have more of a chance of being acted out in public ; on the other hand,

as family cohesion slackens and as parents more and more get accustomed to regard the upbringing of their children as the responsibility of school and other Government agencies, there may no longer be so strong a tendency to maintain the honour and integrity of the family at all costs. Parents may no longer hesitate to disclose the awkward secret of a child's antisocial behaviour, which probably, in former times, they would have borne with and concealed to the utmost limits. So, already now, children who have been brought voluntarily for psychiatric consultation, even though the delinquent features noted in them may not have been the main reason for their parents' worrying, can indicate to us a need for future developments in judiciary and correctional facilities for juvenile delinquents. Insofar, the communication of these observations of ours may serve some practical purpose.

Perhaps, however, we may, at the same time, gain some theoretical insight into the more subtle factors that can deflect a child's development towards delinquency. If parents are willing to spend time, money and personal concern on taking a child to a private psychiatric clinic without any pressure by an official authority, we must assume that these parents have at least a minimum amount of interest in and responsibility for their children's welfare. It is then hardly to be expected that the children examined under these conditions would belong to the category generally termed as "misery neglect". If there is neglect involved at all, it would be more likely to be of the "luxury neglect" type. Expressed in other, less extreme terms, we may find parents and a general family atmosphere, by which the child's vital needs are covered, but in which the proper emotional shelter and nourishment is lacking. Gaining knowledge about factors of this kind, might again help in future to enlighten and guide the often quite willing, but helpless and ignorant parents and guardians of children with deviant behaviour. For those cases, on the other hand, where parents are not really interested in a permanent solution of their problems, but merely want to calm their conscience by a casual consultation, one might have to think of developing provisions for enforcing treatment of the child at a child guidance clinic or even a residential home and, at the same time, some guidance or even psychiatric treatment for the neglectful parents.

The 22 cases about which we can report, are probably only a very small sample of difficulties that must exist in many families. From the far more numerous case-histories of our grown-up patients, we know, how often the onset of neurotic development or even of a psychosis was marked by deviant behaviour very similar to that which we found in these children. The question is, how to find cases of this kind, and how to win them for suitable treatment, if possible at an early stage, at which the distortion has not become too rigidly fixed yet.

As our material demonstrates, the setting up of child guidance clinics would in itself attract and provide for quite a good number of delinquent and predelinquent children who otherwise would hardly come to the notice of any authority. Amongst the 208 Indian children seen at Nur Manzil Psychiatric Center between April 1956

and December 1961, 15 cases, *i.e.* 7.2 per cent, have been singled out as presenting definite delinquent features, while 7 further cases (3.3 per cent) have been added in a separate group, as they are apt to illustrate, what is sometimes called "potential delinquency" or a "pre-delinquent" stage.

If these figures of ours can be taken as representative, we might expect that the case-load of any child guidance clinic would comprehend at least 10 per cent of children with delinquent features. If schools, youth organisations, doctors and other individuals and authorities dealing with children were properly informed about the services available, the number might even be considerably greater. It may be significant that, of the 22 children under discussion, 15 were brought by their parents, either on their own initiative or after having heard about our Center from former patients. Five were referred by doctors, one by a lecturer of Lucknow Jail Training School, and only one by a teacher ! An officially established and advertised child guidance clinic might certainly count on having children referred from more sources and, with the necessary backing by appropriate authorities, it might also succeed in keeping them under observation and treatment beyond the stages of initial investigation.

The Delhi Child Guidance Clinic (5), whose figures we have already used for comparison in other respects, in its annual reports for the last 5 years, gives percentages between 2.7 per cent and 5.6 per cent of children who were referred for lying, stealing and truancy. Possibly there may be a few cases that would correspond to what we have termed "delinquency" amongst the cases listed under "aggressiveness, violence and destructiveness". It is rather surprising that this clinic, to which cases are referred from many official agencies, including the Juvenile Court, does not register more cases of delinquent behaviour, so that their figures even remain behind the 7.2 per cent of cases which we marked as "delinquent" in our material.

In his recent paper (6), Bassa gives the following figures for antisocial behaviour amongst 50 children examined at 2 Child Guidance Clinics in Bombay : stealing 2, lying 1, truancy from home 3, *i.e.* altogether 12 per cent of the total material. Amongst 27 private cases, he mentions 1 case of stealing. Sources of referral to the two Child Guidance Clinics were, amongst other, social workers, teachers and a remand home. It may be interesting to compare these figures with those of the Swiss out-patient department for child psychiatry at Basel, of which we have given some statistics earlier. To this department, quite a number of cases are referred by the Juvenile Court and child protection authorities, not only for expert investigation, but also for treatment. Between 1956 and 1961, the figures for juvenile delinquents fluctuate between 2.5 per cent and 14.3 per cent. Probably they do not reflect actual variations in the incidence of juvenile delinquency in this city of about 200,000 inhabitants and its surroundings, but more some administrative changes which took place during these 5 to 6 years. As far as the author knows, the term "juvenile delinquency" in these reports only designates children who had actually come into contact with the police and the Juvenile

Court, while the figures for the 3 Indian cities include children and adolescents in whom such symptoms as lying, stealing, truancy had been reported by the parents or other interested persons, though the child had not been officially apprehended by the police.

In the private setting in which our observations were made in Lucknow, 9 of the 22 children with delinquent features were only brought for one consultation, 7 further ones only for two consultations, one child each for 3 and 4 visits. Only 4 children really had a chance of profiting by treatment : one during 6 interviews, one during 8 visits, and two for prolonged periods, one of them even as an in-patient for some time. In all these latter cases, due attention was also given to the problems of the parents. Two of the mothers were seen regularly during the whole period of treatment of the child. The father of one little girl had been in regular psychotherapy himself for some time, before he realized that the child and his wife also needed help.

In dividing the whole number of cases into a group of 15 children who had already developed open delinquent behaviour and a smaller one of only 7 children who might be called "pre-delinquent" or "potentially delinquent", the author is very conscious of the fact that literature on juvenile delinquency is full of controversy with regard to these two latter terms. One argues that every child is in theory a potential delinquent and therefore also pre-delinquent, but on the other hand, one points out that by labelling any young person with one of these terms more specifically one can do him or her serious injustice, as the vague, ever-present tendencies may never develop into concrete action. The few cases assembled in our group of "potential delinquents", all of puberty age, are partly meant to demonstrate that certain forms of emotional conflict and dysbalance are more likely than others to deteriorate into outright criminality, partly to show, how universal and perhaps almost "normal" certain antisocial trends may be, particularly at puberty age, at which individual conscience and responsibility begin to emerge, and how thinly such tendencies may be veiled by a bland surface of various neurotic symptoms. The study of the few cases permitting glimpses into dream-and phantasy-life, in which criminal tendencies were freely lived out, while in real life an obedient, dutiful, perhaps even compulsively law-abiding facade was kept up, may make us wonder, what subtle factors ultimately decide, whether the dark forces within each of us remain mere shadows, or whether we allow them concrete manifestation in our actions.

2. *Characteristics of our Material.*

(a) *Distribution according to Sex and Age.*—While in the group of "potential delinquents" all children are between the ages of 11 and 16, the group of actual delinquents presents a slightly more varied distribution according to age :

Table 27

Distribution of Children with Delinquent Features according to Age.

Age in years :	Delinquent			Potentially Delinquent		
	Male	Female	Total	Male	Female	Total
6—7	—	1	1	—	—	—
7—8	—	1	1	—	—	—
8—9	—	—	—	—	—	—
9—10	1	—	1	—	—	—
10—11	1	—	1	—	—	—
11—12	1	1	2	1	—	1
12—13	1	—	1	1	—	1
13—14	3	—	3	—	1	1
14—15	2	—	2	3	—	3
15—16	3	—	3	1	—	1

From Table 27, giving the distribution according to age, one can at the same time see the rate between the sexes : In both groups, the boys are in the majority : Amongst the delinquents at a ratio of 4 : 1, amongst the potential delinquents even 6 : 1. The predominance of boys and men amongst juvenile delinquents and adult offenders, is a fairly general phenomenon in all countries. Here in India, and particularly for this young age-groups, it may be accentuated further by the fact that girls and women still have less chances of moving freely and independently in surroundings that would give occasion for delinquent acts and which would at the same time expose them to discovery.

(b) *Education.*—The distribution according to educational standards (Table 28), apart from relating to age, is of course in close connection with the diagnostic classification of the cases, which will be given later. Mental deficiency and epilepsy naturally tend to lower the standard of scholastic attainment or may even render formal education quite impossible. Failure and retardation in classes beyond primary stage may, however, reflect neurotic conflicts. The fact that a child is taught at home, does not in all cases mean that an attempt at schooling has failed or not been worthwhile, but may be an expression of the conservative or overprotective attitude of the parents.

Table 28
Educational Standard of Children with Delinquent Features

	Delinquent			Potentially Delinquent		
	Male	Female	Total	Male	Female	Total
No formal education or complete failure	1	1	2	1	—	1
Taught at home	3	1	4	—	—	—
1st-4th class						
according to age	—	1	1	—	—	—
below age	2	—	2	—	—	—
5th-8th class						
according to age	4	—	4	—	—	—
below age	1	—	1	2	—	2
9th-10th class	1	—	1	1	1	2
according to age						
Intermediate						
according to age	—	—	—	2	—	2

The most striking fact is perhaps that, with one exception, the adolescents whom we have characterized as "potentially delinquent", all belong to a relatively high educational standard. This is partly explained by their age ; it might however, also mean, at least in certain cases, that young people who are enjoying the benefits of prolonged education, have developed some inward control that checks them from outright delinquent activities.

(c) *Local Origin*.—The majority of the children (12), were living in Lucknow itself, while 3 had come from other big cities and 7 from small country towns in U.P. and Bihar. Only two boys had undergone major changes in their surroundings : one whose father had recently been transferred from South India to the North, another one who originally living in Bombay, had been shifted to various boarding-schools, last in U.P. One boy, from a neighbouring town in U.P., was brought by an uncle in Lucknow, while another boy had come to live in Lucknow with relatives, after both his parents in the village had died. This latter boy, as well as two other ones, can be said to be of rural origin ; at the time of consultation, however, they had been living in the city for some time.

(d) *Community and Caste*.—The percentage of Hindu children, with 66.6 per cent amongst the delinquents, 57.1 per cent amongst potential delinquents, remains behind the average for the whole material (70.7 per cent). The rates for Muslims, with 20 per cent and 28.5 per cent respectively for both sub-groups, rather tend to go beyond the average of 19.7 per cent for the whole material. The presence of two Sikhs and one

Christian child, within this small total number, can hardly be taken to indicate anything more than an accidental incidence. (Table 29).

Table 29

Distribution according to Community and Caste of Children with Delinquent Features.

	Delinquent			Potentially Delinquent		
	Male	Female	Total	Male	Female	Total
Hindu total	8	2	10	3	1	4
Brahmin	2	—	2	1	—	1
Kshatriya	1	2	3	—	—	—
Kayasth	2	—	2	—	—	—
Baniya	—	—	—	—	1	1
Shudra	—	—	—	1	—	1
Caste ?	3	—	3	1	—	1
Muslim	3	—	3	2	—	2
Sikh	1	1	2	—	—	—
Christian	—	—	—	1	—	1

As to the caste amongst the Hindu children, this was not identified in all cases. For the few remaining ones, the distribution can hardly have any relevance, except perhaps for the fact that, according to common notions about delinquency, one might have expected more children from the scheduled castes. One has, however, to remember, that our material is not typical at all for general incidence of juvenile delinquency, but is made up of a selected group of children, whose parents and guardians had a minimum of concern about their misbehaviour and who even took the trouble to seek some remedy for it !

(e) *Occupation of Father or Guardian.* (Table 30)

Table 30

Distribution according to Occupation of Father or Guardian of Children with Delinquent Features.

	Delinquent			Potentially Delinquent		
	Male	Female	Total	Male	Female	Total
Academic Professions and high positions in Service	6	1	7	1	—	1
Service (Junior)	1	1	2	4	—	4
Business	5	1	6	—	1	1
Farming	—	—	—	1	—	1

The same reflection just made at the end of the last paragraph applies to the occupational classes from which the children came : We need not be surprised to find a considerable number of young delinquents and potential delinquents from families of most respectable social status and none of the class of labourers and lower crafts, as those belonging to the latter would hardly be brought to a psychiatric center by their parents, if they indulged in antisocial behaviour.

(f) *Lack of Parents*.—Only one of the children had lost both parents, while one other boy, an illegitimate child, had been adopted by a divorced woman living with her mother. All other children had both parents living.

(g) *Position in the Sibling-Row*.—As this group is made up of children from various diagnostic categories, for which the exact figures for number of siblings and position in sibling row have already been given, the detailed percentages for possible and actual special positions have not been calculated, as they could hardly have any significance for so heterogenous a group. What matters, is the particular positions in which each individual child stood within his or her family ; these details, however, will be found in the case-histories.

Summing up roughly, we can say that 13 of the 22 children occupied special positions of some kind. Of the 9 remaining ones, one is the adopted boy, *i.e.* an only child, whereas 6 are placed somewhere in the middle of numerous families with more than 6 children, so that only 2 children remain, whose position amongst their brothers and sisters does not suggest any point of importance.

(h) *Parental Attitudes*.—No special position within the sibling row necessarily presents a risk in itself ; the child is always “someone’s eldest or youngest one”. In other words, the attitude of the parents is a significant factor, though any special position of the child within the sibling row may tend to accentuate any harmful tendencies in this attitude.

Peculiarities in character and attitude of one or both parents can in fact be shown up for all of our young delinquents and for most of the potential delinquents. We find overambitious parents, neglectful parents, short-tempered, intimidating fathers, nervous, irritable and inconsistent mothers, fathers who are absorbed in their professional duties and even some mothers who prefer their social life or some work outside the home to their natural place amongst their children ; on the other hand, we also find pampering, overanxious parents, who do not dare to refuse any wish to their darlings.

In tabular form, adapted to the method in which we have presented this feature in the preceding chapters, we get the following distribution of parental attitudes :

Table 31
Parental Attitudes in Children with Delinquent Features.

Parental Attitude :	Delinquent			Potentially Delinquent		
	Male	Female	Total	Male	Female	Total
Expecting too much	2	1	3	1	1	2
Pampering	1	—	1	—	—	—
Overanxious	—	—	—	1	—	1
Accepting	—	—	—	3	—	3
Inconsistent	4	1	5	—	—	—
Neglecting	1	—	1	—	—	—
Rejecting	4	1	5	1	—	1

This table shows that, for the children who had already performed delinquent acts, the weight is undoubtedly more on the negative parental attitudes. Inconsistent parental behaviour may of course, in some cases, include spells of unreasonable pampering. Even then, however, the uncertainty of what to expect on the next occasion, combined with the experience of immediate fulfilment in certain instances, may create a particular inability to postpone gratification of needs and desires. Complete rejection, which is equally frequent, breeds attitudes of spiteful resentment against any social order, unless, in the emotional vacuum of an atmosphere of this kind, individual limits remain so diffuse that they even cannot be applied to the physical distinction of property and personal rights.

Excessive parental expectations, as we found them in 3 cases, again can provoke a reaction of spite and aggression, and a tendency to compensate oneself for hardship and strain by illegitimate enjoyment, or to escape from criticism and punishment by lies or by running away.

Plain pampering and overindulgence, what one might call "luxury neglect", accounts for one case ; neglect not amounting to complete rejection, for one other.

For the group of "potential delinquents", the figures seem to be less extreme. In particular, we have listed 3 cases as having enjoyed "normal acceptance". Two of these are epileptic children, in whom the risk of becoming delinquent lay mainly in their insufficient control over consciousness ; the one neurotic boy in this column has already been presented: Rehman (76), who after having enjoyed a fairly well-sheltered childhood, at the age of puberty was suddenly exposed to a wider world and increased responsibilities, when his father was transferred.

In classifying these cases, the author was often in dilemma : is one to place a case into the column of "expecting too much", because the parents' demands and ambitions are beyond the child's capacities ? Or should this same parental attitude be

characterized as "neglecting" or even "rejecting", because it does not really take account of the child's true needs and rejects him, as he really is? One realizes that the top and the bottom of our scale of parental attitudes are not as far apart as one may think! Ultimately, all the attitudes listed, except what appeared as an honest attempt at understanding and accepting the child, spring from the parents' inability to recognize and to care for their children as separate human beings with their individual needs and possibilities. If, in some more or less subtle way, instead of being fed and sheltered by the parents, the child is "fed upon" and expected to provide protection and prestige, having to "give" too early and perhaps not receiving what would meet his particular needs, he may misinterpret the vaguely felt lack of "something" in terms of material satisfaction or emotional abreaction; this he then obtains in a way that is unacceptable to society. What exactly leads to this type of acting out which we have to regard as "delinquent", *i.e.* as leaving the path of righteousness, while in other children the same situation of emotional frustration may lead to symptoms that do not offend against law and order, still remains a mystery. In the individual case we may be able to point out that a delinquent act was either the easiest or perhaps the only possible way out of tension. But to give a general "recipe", of what combination of factors will produce delinquent behaviour, in spite of all "prediction scales" attempted by Western authors [see *e.g.* Glueck (37)], still appears to be an impossible or at least highly doubtful enterprise.

(i) *Diagnostic Categories.*—Most of the factors which might be held responsible for the deviations of any of the children in our two groups of "delinquents" and "potential delinquents" can just as easily be found in the case-histories of other children who had been observed at our Center. In fact, all of the children in these two sub-groups were not in first line labelled as "delinquent", but have already figured in the diagnostic categories summed up in the preceding chapters. Table 32 gives the distribution of the cases according to psychiatric diagnosis. The total figure of all children classified in each group is added, so as to give some idea, what percentage of each group shows delinquent features.

Table 32

Distribution according to Diagnostic Categories of Children with Delinquent Features.

Diagnostic Category :	Delinquent :			Potentially Delinquent			Total of children in diagnostic group
	Male	Female	Total	Male	Female	Total	
Mental Deficiency	4	1	5	—	—	—	64
Postencephalitic	1	—	1	—	—	—	35
Epilepsy	—	—	—	3	—	3	19
Neurosis	7	2	9	3	1	4	54

The following diagnostic groups into which we had classified our young patients are not represented amongst the delinquents: the small "organic" group, "infantilism", "infantile psychosis" and "adolescent psychosis".

The organic children were all seriously handicapped and already brought for examination at a young age ; they were probably too well protected to go into delinquent activity, even if such tendencies had been present. The children in the group of "infantilism" and "infantile psychosis" are equally mostly aged below 6. Furthermore, they solve their problems in a way that will either be considered as simply "childish" or then "crazy". Even if they take away things or go into aggressive and destructive behaviour, as we have seen it in several of the children considered as psychotic, this is not experienced by their surroundings as a transgression of acknowledged social norms, but as something for which the child has neither understanding nor responsibility. The same lack of insight and responsibility is generally assumed for the antisocial acts of an obviously psychotic adolescent or adult.

It is rather surprising that we do not find more of the postencephalitics amongst our delinquent children. Encephalitis in children is often followed by character changes that dispose them towards all types of wicked and uncontrolled behaviour. Again, as in the group of children with other organic diseases, we may suppose that the parents are sufficiently aware of the handicaps of their children to avoid exposing them to situations in which they might come to harm or damage others. In the only case of a postencephalitic boy, his organic handicap was complicated by the neurotic consequences of his being a pampered eldest and for a long time only son.

As to epilepsy, though it can predispose to certain types of criminal behaviour, it may not be the sole factor responsible. Two of the boys classified as epileptic in the group of potential delinquents, had only started their fits at puberty age, possibly more as a result of neurotic tension on the basis of slight brain-damage.

Even in some of the mentally deficient children, delinquent behaviour was not exclusively a consequence of lack of judgment and ill-controlled emotions, as one might suppose, but rather an expression of superimposed neurotic development. Quite a number of the oligophrenic delinquents were exposed to particularly negative parental attitudes.

(i) *The Delinquent Features.*—Before we give the individual case-histories, we must, what should perhaps have been done right in the beginning, show what delinquent features and combinations of them we found in our patients. So as to demonstrate within one table, how many cases presented a combination of features, is being each case listed with its number and name, grouped diagnostically.

One will note, when inspecting the second table (Table 33 b), registering the delinquent features and combinations of them in "potential delinquents", that the two diagnostic groups : epilepsy on one hand and neurosis on the other, present pictures distinctly different from each other. While, in the 3 epileptic cases, we find in each at least one of the classical symptoms : running away, truancy, stealing, telling lies, the neurotics seem to specialize in aggression ; and not even this is always openly acted out, but may only play a role in phantasy, dreams or results of projective tests.

We must admit, at this point, that perhaps the two groups represent slightly different concepts of "potential delinquency". While in the neurotic, the unconscious "potential" tries to force itself into the young persons' consciousness, but is met with determined and often desperate attempts at suppressing it, allowing it an outlet only in imagination, the epileptic periodically may get into a state in which the antisocial impulses find their way out into action, while the patient, so-to-speak, is "outside himself", in a state of abnormal consciousness, which later he may not remember. If the illness progresses, the patient may finally deteriorate into a state in which a certain lack of control over his impulses establishes itself as a permanent feature. In one of our cases, delinquent behaviour only occurred in phases of abnormal consciousness, which had been noted since the age of 13½, about 6 months before the first consultation. In the second case, the epileptic fits had been observed since early infancy, and the boy had deteriorated into a state in which apparently only parental control was preventing the uninhibited impulses from resulting in criminal action. In the third case listed amongst epileptics [Edward(60), already quoted in the chapter on epilepsy], a 14 year old boy, whose epileptic fits were probably due to a brain-injury sustained earlier in childhood, the delinquent features seemed to be less due to the epilepsy as such than connected with his puberty development in an unfortunate family situation. The seizures and changes in connection with this handicap might however create conditions, under which unconscious impulses can escape the usual control more easily than in a merely neurotic boy.

While thus these 3 epileptic boys, to whom we might add one of the neurotic boys with hysterical fits, may provide an example for one of the factors, *i.e.* reduced control over consciousness, which may allow latent delinquent tendencies to become manifest, the remaining 3 neurotic "potential delinquents" have been selected to demonstrate the powerful presence of such delinquent tendencies under a surface that would not lead one to expect them. Increase of pressure or tension, or, on the other hand, any weakening of conscious defences, *e.g.* through a physical illness, lack of security, some sudden shock or state of anxiety or perhaps a situation of excessive temptation, might lead to a constellation in which this "potential" could actualize itself.

Outright sexual offences had not been observed or reported in any of the children or adolescents in our material. Some were suspect of having had some homo-sexual experience. Any such practices, however, wherever present, probably had more the character of playful engagements with willing partners. While, thus, they might be regarded as "delinquent" from a merely moral point of view, they would hardly deserve the name of criminal acts.

One might perhaps have added, as a special form of delinquent behaviour, the case of the boy [Vivek, (99)] who was caught cheating in his exam. This, however, would stretch the limits of "delinquency" too far.

3. *The Individual Case Histories.*

Though, what has been discussed up to now, may already have given some idea about the common characteristics to be found in our two groups of actual and

potential delinquents, no mere statistical analysis can replace the living freshness and immediate appeal of the individual case-history with its complicated interaction of factors and tendencies. We shall therefore now base any further considerations and commentaries on the summaries of those cases which have not been presented yet in their respective diagnostic categories.

(a) *Delinquent Group.*

(1) *Mental Deficiency.*—Of the mentally deficient children in the “delinquent group”, one was classified as “moron”, *i.e.* only presenting a slight lack of intelligence, 3 as imbecile, one of them combined with epileptic fits, while one has to be considered as an idiot. As already mentioned, some of these cases may not present any psychodynamic problem, but rather demonstrate, how essential good parental care and protection are in preventing seriously handicapped children with insufficient understanding, discrimination and emotional control from committing antisocial acts. In some of our patients, however, neurotic factors are so tightly interlocked with the mental weakness, that it may be difficult to decide, whether the escape into delinquency is more due to the basic lack of control and discrimination or more to an excessive accumulation of emotional tension.

This interaction of the different factors can be demonstrated by a first case :

- (140) *Arjun*, a boy of 9, son of a tahsildar in a country district of U.P., Hindu, Kaisth, was brought by his parents on advice of the family doctor, because of mental backwardness and generally delicate health. A particular problem was that the boy asked people for money and even took money from home and then gave it away to other children. He seemed to have no idea of the value of money. Once he even took a 10 rupee note. He embarrassed his father by asking his clerks for money. At first sight, particularly when we heard that Arjun, though going to school for the last 3 years, could only count up to 100, but not do any sums, one was tempted to suppose that this “stealing” merely betrayed his lack of discrimination. He was giving as easily as he took, probably not having realized the limits of individual property yet.

When we learned more about his history, however, we no longer felt so sure, whether his taking and distributing money did not have its roots in emotional conflicts.

The father, who came with the child, seemed to be very badly informed about his son. He knew practically nothing about him. The mother impressed us as being rather dull and passive. Both parents unanimously complained : “He is a constant nuisance to us.” They had tried to “reform” the boy by slapping him, and his two elder brothers also seemed to have a free hand in giving him severe beatings. Even at that point, one could still think that this parental attitude might have been merely a reaction to the boy’s dullness. But then we heard

that, after having produced two sons, one 7 and one 5 years older than our patient, the parents did not want any further children. While the mother was pregnant with Arjun, she attempted an abortion, but had no success. The slight mental deficiency and general backwardness in the boy was associated with some signs of physical malformation that made one suspect that the unsuccessful attempt at abortion might have damaged the embryo. Typhoid at the age of 4 caused a further setback in the already retarded development.

Knowing that the child was unwanted and that his physical and mental weakness might have been a constant reminder to the parents of their prenatal attempts at eliminating him, one now understands that the child must have grown up in an atmosphere full of more or less open rejection.

The birth of a healthy younger brother, when Arjun was aged 7, just at the time when he was starting school, may have thrown him out even more completely from the little of affection and concern he still enjoyed from his parents. His "stealing" of money, though certainly lack of discrimination and understanding about the nature of property played their role in it, may thus have been an attempt at taking some substitute for the love and attention which his family denied him and, at the same time, a means for "buying" affection from other quarters.

After the first two consultations, the parents did not return with the boy, and it is doubtful, whether they even followed our advice to have his heart examined for a possible congenital malformation. At that stage, the child could probably easily have been helped by proper attention to his physical weakness, by adequate teaching methods and, above all, by a certain measure of kind, patient and steady affection from a well-meaning adult, not even necessarily a psychotherapist. The parents, on their part, might have profited by some guidance. As it is, we cannot guess, how the child might have developed in later years.

A similar amount of parental rejection seemed to be involved in the next case, a girl, whose mental deficiency was of more pronounced degree. While Arjun would fit into the category of morons, Kunti has to be classified as "imbecile."

- (141) *Kunti*, a 7 year old girl, tall, strong and well-fed for her age, showed signs of prenatal brain-damage. Her speech was badly articulated, agrammatical, and she moved in constant restlessness and with uninhibited inquisitiveness. The girl, 7th of 9 children of a contractor, Hindu Kshatriya, had been abnormal since delivery, which was prolonged and complicated.

Up to the age of one year, she was so unresponsive, that the parents doubted, whether she could even hear and see. She started walking and talking late and wetted her bed up to the age of 5 to 6 years. Two attempts at sending her to school, failed completely. Apart from her general mental backwardness, the

symptoms for which the parents brought her for consultation were : roaming about, stealing and hiding things, tearing clothes, throwing away things, lack of inhibition with strangers, disobedience.

In this case again, we learned that the family were fed up and disgusted with the child. She got a lot of beating, but had become so hardened, that not even this form of punishment impressed her. No one seemed to bother about her.

Again one might try to justify the mother's exasperation and the father's angry reactions by the very obvious difficulties, the child was presenting. We heard, however, that the mother was not only "fed up" with this one difficult child, but quite generally with the task of caring for a big family. She did not want to work and, at the age of 35, resented that she did not have a daughter-in-law yet, who could have taken over her household duties.

One of the girl's elder brothers, at the age of 17, was still in 3rd class and had become a careless loafer. We could not find out, whether his trouble was due to mental deficiency or to parental neglect.

During examination at our Center, the girl, though very obviously mentally handicapped, and emotionally uninhibited, showed herself quite affectionate and capable of taking an interest and learning, when taught patiently and with some personal concern.

It was clear, in this case, that the parents had not come for the child's sake, but only in order to get some —perhaps magic-relief from their own worries. When they realized that no quick cure could be obtained, but that a questioning of their own attitude would also be involved in any attempt at treatment, they did not return after the first consultation.

An uninhibited, mentally deficient girl of this kind who, due to parental carelessness, is allowed to roam about outside home, will not only get into delinquent behaviour easily herself, but also runs considerable risks of becoming the victim of some criminal act, particularly of some sexual assault.

A next child, though impressing one as imbecile, still seemed to be sufficiently alert to experience his handicap as shameful and embarrassing and reacted to his situation as the eldest son and the parental rejection on one hand with neurotic anxiety, on the other hand with uncontrolled outbursts of temper :

- (142) *Kishan*, 14½ year old son of a Hindu doctor (caste unidentified), living in a U.P. country town, was brought by his parents on recommendation of one of our former patients, because he was mentally dull and had not been able to profit by any schooling or tutoring. He got easily frightened, would not go anywhere

alone ; on the other hand he was stubborn, inquisitive, had no sense of shame and delighted in teasing and beating other children. The parents described that his aggressiveness was particularly turned against his two younger brothers, while the two sisters, one elder, one younger, did not seem to provoke his anger. If someone got hurt or fell, he would laugh and show great pleasure. He had no regard for his elders, tried to exercise authority over the servants, did not obey and resented any criticism. He was very destructive. His father feared that, if left alone, the child might strangle his younger brothers or set the house on fire.

The boy was obviously full of aggression and resentment, stirred probably by his having been dethroned from the once unique position of the eldest son by more intelligent and amiable younger brothers. But his anxiety, in particular his fear of being alone, seemed to indicate that some inner control or at least an awareness, though a very helpless one, of the aggressive and destructive urges was taking shape. Up to that time, parents as well as teachers seemed to have been threatening figures who, by their beating and scolding, had merely discouraged any interest and ability in learning that might have been present. Probably the child's mental deficiency was of a much milder degree than it appeared, after neurotic inhibitions had been superimposed. He obviously had not had any help in building up an inner control authority, though, as his anxiety indicated, rudiments of it were present and could probably have been developed. As it was, with the parents' lack of interest in treatment beyond the first two visits, one wondered, what would become of the boy, if the new energies developing at this age of puberty were to threaten even more to overwhelm him.

What may happen, if even this rudimentary inhibition of new energies at the time of adolescence is not available, is demonstrated by a next case :

- (143) *Gur Bachan* was a 15½ year old Sikh boy, 5th child of an engineer, who, with a salary of Rs. 1,500/- a month, was in a good position to provide for his 9 children.

Gur Bachan had always been mentally backward and neither visiting school nor being taught by a tutor had left any impression on him. He could only do some simple sums up to 15.

During the last 6 weeks before he was brought for consultation, he had started having fits, probably of epileptic nature. At the same time, he became very aggressive and destructive, threatening to kill someone, once even trying to act out this threat by catching hold of a sharp instrument. Once, in a fit of anger, he destroyed all the electrical fittings in a room. When trying to associate with other children, he became the object of teasing and everyone took pleasure in making a fool of him, thus of course again provoking his anger.

Though the father was described as tolerant and loving, he had found that the only way to deal with this problem-son was to tie him up with chains !

In this case, in which we prescribed some tranquilizing and antiepileptic medication, the parents came back after a fortnight to report some improvement. Later, we heard nothing further about the boy.

In the last case of this group, in which mental deficiency almost amounted to idiocy, *i.e.* the most severe degree, there could hardly be any question of a neurotic superstructure. We quote it just to show, what problems a severely mentally deficient child of the erethic type can present :

- (144) This 15 year old Muslim boy, *Hussain*, was the second of 8 children of a shopkeeper. All his brothers and sisters, though none of them brilliant and keen on learning, were fairly well developed. They lived in a big joint family of 40-45 members. The father was described as quiet and understanding, while the mother, a hardworking woman of 27, at times lost her temper with Hussain.

In general, both parents tried their best to control the child either by bribing him with food or money or then by tying him with a rope, so that he could not do any harm. The child developed slowly ever since birth, but, though in early infancy he occasionally had convulsive fits, it was only the age of 3 that the parents realized that he was definitely abnormal. At the age of 15, the boy could not speak properly and had not learned to take care of his toilet needs. He resented any obstruction of his wishes and then would get into violent fits of anger. At other times, he would run away and roam about for a few days. He used to take money from home, without consideration for its value, and with it would buy tea and sweets from some stall. When roaming about, he rushed across the streets without any sense of danger and had already been involved in several traffic accidents. When, at puberty age, his physical strength had increased, 8 men were needed to hold him, whenever he was to be given a bath or to have his hair cut !

Some training to a strict routine in a special home for deficient children might have helped this boy at least to be able to take care of his own needs. He might then not have become a menace to his family and even to society in general.

(2) *Postencephalitic State.*

The only boy classified as postencephalitic, presents similar problems of lack of control as the mentally deficient children. But, as already mentioned earlier, his case is complicated by obvious neurotic tendencies :

- (145) *Amarnath*, aged 13½, son of an engineer, Brahmin, developed normally up to the age of 9, though his delivery was complicated and he probably sustained

some brain-damage during it. He was breastfed only for one month. Being the first son in the whole family, he was excessively pampered, and of course the expectations and ambitions of his elders were concentrated on him. First, their fond hopes were duly rewarded. Amarnath proved to be an intelligent boy, interested in his studies, obedient and good to his 3 younger sisters. Within his first 3 years at school, he completed the programme of 5 classes. Then, when the boy was aged 9, he fell sick with "typhoid", which kept him in bed with fever for 4 months. We do not know, how far the diagnosis was confirmed. According to the changes in character, which the boy underwent after this severe illness, an involvement of the central nervous system, probably by a form of encephalitis, seems highly probable. The formerly alert, intelligent, obedient and well-mannered boy became mentally dull, reluctant to study, quarrelsome, careless, mischievous and destructive. While formerly an excellent pupil, he now had to repeat every class. He started running away, threatened to leave home altogether and at times stole money. His only interest were fine clothes, expensive food, visiting the cinema and roaming about. Perhaps it may be significant that, during the time when the boy was recovering from his illness, a first brother after 3 sisters was born. Since then, another brother was born, but died at the age of 18 months, while the youngest child, aged 2 months, was a sister again. Possibly some of the behaviour disturbances observed in the boy may not have been exclusively as consequence of some brain-damage, but a neurotic reaction to seeing himself frustrated in his own ambitions, not only through the setback caused by the illness, but also by his losing his unique position as the only son. The parents, disappointed in their high expectations, were "fed up" with the boy by the time they came to consult us. They had tried to guide him with love, then with strictness and beating, but they found that Amarnath defied all their attempts and that he was becoming a bad example for all the younger children in the family.

The boy was not brought back after a first consultation ; so we do not know, whether our explanations and advice to the family and our prescription for some sedative and nerve tonic had any success.

(3) *Neurosis.*

The emotional strains and conflicts which we have already seen at work in the children with a basic weakness of intelligence and nervous system in general, appear of course even more clearly in those young delinquents who were classified in the neurotic group. We shall attempt to group these 9 cases according to the parental attitudes to which they were exposed.

Excessive parental demands and expectations seemed to have driven 3 children into neurotic defences with delinquent features. Rita (86), the unwanted child of one of our male adult patients, whose parents first neglected her quite drastically and later

all the same expected her to behave like a good little girl of her actual age, has already been presented. She is listed amongst the delinquent children, because she had started taking small sums of money. Also, she at times showed quite uncontrolled aggressiveness and furthermore had taken to telling phantasy-lies in order to gain attention.

A similar parental attitude, of which one does not quite know, whether to classify it as "excessively demanding" or "neglecting", was frustrating a 10 year old South Indian boy :

- (146) *Premnath* was the eldest son of a doctor, who had moved to Lucknow from the South about one year before we got to know the family. The well-to-do parents, both busy in medical work, were puzzled and worried by the fact that recently the child had lacked attention and concentration in his school-work, that he had started stealing small sums of money from home and that he had become more dreamy and withdrawn. When we heard that, after having had a double promotion on his coming to Lucknow, the boy was already in 7th class, but unable to keep up with his companions in this different language area, we first supposed that the change in his surroundings, his being uprooted from his early childhood home in the South, might sufficiently account for the neurotic disturbances and signs of beginning delinquency. This impression was confirmed when we learned that, shortly before the boy had left the South, his maternal grandmother, of whom he had been very fond, had died and that he had been missing her a lot. Furthermore, while in the South, on a big plantation and surrounded by a numerous joint family, he had had ample opportunity to roam about in the jungle with cousins of his own age, he now had to live in a small city flat with only his two younger sisters as companions. His comrades in school were teasing him for being different from them. Apparently disoriented by this new, frustrating situation, he had already received beatings in school and by his parents, measures that were naturally not apt to encourage and console him. He started taking away small sums of money, which his mother had kept ready for the milkman. With this money, he bought ice-cream for himself and his friends. Again, as in a former case (140), he not only tried to compensate himself for the lack of affection at home, but at the same time used the fruit of his thefts in order to "buy" love and friendship.

Though these frustrating influences that had been operating recently might have been sufficient to explain the boy's deviations, we found, on further exploration, that they had only reinforced an already existing neurotic situation : *Premnath*, the first child of an 18 year old mother, was eagerly expected and was the object of pride and interest, not only of his parents, but of both couples of grandparents, who lavished a lot of pampering care and affection on him. When the boy was aged 3, a first sister was born. She was shy, sullen and withdrawn, and the patient resented her lack of interest in playing with him. When he was aged 7,

a second sister was born. Soon after this, both parents, together with this baby, left for England for further studies, while the patient and his first sister were left with the grandparents in South India. At that time, the patient began to get fussy about his food. In school, in spite of his having a special tutor, he did not come up to his parents' expectations. But one wonders, how, without intelligence and effort, he could possibly have arrived in 7th class at the age of 10 ! It looks, as if the parents, both overrating intellectual performance, had demanded far too much from the small, thin and spindly boy.

During the only two visits to our Center, the boy first was very serious and reserved and hesitated to express himself about his problems. We had to use indirect methods of play to guess something of the anxiety, insecurity, resentment and aggression that were troubling the child.

In spite of all their education and emancipation, the parents did not take our warnings seriously. The only thing they seemed to have grasped from our explanations was that they had omitted to give the boy some pocket-money, as it is customary in a city. Apart from this, the only measure they thought fit to remedy the situation, was still another change of school !

A further case, in which inadequate expectations provoked not only depression, but also delinquent features, is that of an adopted child :

- (147) *Dinesh*, aged 11, was brought for consultation by a robust, stately matron of about 40, who complained in rather reproachful tone that the boy was taking no interest in his studies, only wanted to play and at times ran away and even stayed out during the night ; also that he had started stealing money from home. She added that, up to one year age, the boy also used to go into fits of anger, in which he threw and broke things and even attempted to beat anyone who came into his way.

The social worker, on taking the family history, found out that *Dinesh* originally was the illegitimate child of a Brahmin girl. He spent his early infancy at an orphanage and, at the age of $2\frac{1}{2}$, was adopted by this Kshatriya woman who, being divorced from a useless husband, had no children of her own. It may be significant to know that the foster-mother's family had wanted to give education to her future husband who had come to their house at the age of 15. He seemed to resent these attempts at being shaped according to his in-laws' specifications and ran away. Later, this marriage, which apparently had never properly functioned, was divorced.. The mother went in for further studies and was employed as a clerk at the time when she brought the boy. She and her widowed mother had first tried to bring a little interest into their lives by keeping pets. Later they adopted this child, as, in addition to providing an object for their mothering instincts, he was likely to become a source of income and protection for their old age.

One got the impression that seeing the boy progressing in his studies, was the only concern of the rather harsh, masculine and matter-of-fact foster-mother. Under this pressure, the boy had reached 6th class at the age of 10. At home, he had neither any companions of his age, nor any male family-member who could have been a model and inspiration for him. He even had to share a bed with the two women. The foster-mother at times promised him toys, but, probably as a punishment for his undesirable behaviour, such promises were never carried out. One hardly wonders if, under these circumstances, the boy, who incidentally had never been told that he was adopted, began to escape from this restricting atmosphere. He became restless, broke some of his things, got into other mischief and finally started running away. The crowning event, which led the adoptive mother to bring the child to the psychiatrist, was his taking Rs. 10, while the grandmother was sleeping. With this money, he hired a bicycle and roamed about, then went to a cinema and only came back when, by chance, some relative found him. During the one consultation for which the boy was brought, we noted, in his whole attitude, depression, resignation, seriousness. His answers to some projective tests indicated that he must have been severely restricted and frustrated. When the adoptive mother realized that we were not just going to sympathize with her for her being rewarded with such ungratitude for her generous charity, she did not return for further help.

The obvious result of pampering overindulgence or what one could call "luxury-neglect", was seen in one boy only :

- (148) *Narain*, aged 14, was brought by his elder sister, a 19 year old B.A. student, who apparently was the only family member concerned about the increasing misbehaviour of this thoroughly corrupted youngest son of a Brahmin family. Two sisters still elder were married, one younger sister had died soon after birth. One brother, aged 26, was working with the father in his contractor's business and was bringing up his own children according to the same pattern that had spoilt our young patient. According to the accompanying sister, the whole family atmosphere was corrupted. Everything was only valued in terms of money. She herself only escaped from being influenced by this atmosphere by being brought up in boarding schools from an early age. So, on growing up, she could see the dangers of the parents' materialistic attitude, while everyone else seemed to be so much involved in it, that no one could realize, what disastrous effects it was producing on this youngest son.

The father, little educated, but making a lot of money, was often out for his work for days. He was irritable and obstinate, got angry when obstructed and just tried to keep any trouble away from himself by giving this son as much money as he wanted. To this lack of discipline, the doting mother added her pampering of a son who had not only remained the youngest living child, but who,

at his birth, also had to make up for the recent death of a slightly elder son. He was breastfed for $2\frac{1}{2}$ years and developed fairly normally up to about the age of 11.

Then, while previously he had been one of the best pupils in his class, he started getting careless and finally had to remain in 4th standard for 3 years. He missed classes, roamed about in the company of elder boys and even grown-up men of doubtful character. Already at the age of 14, he had started drinking and smoking. Except for his father, who was seldom at home, he respected no authority. He abused the family-members and became aggressive, if anyone tried to check him. As he could get money freely from his father, he apparently had not tried to steal yet. But his whole appearance made one suspect very much that he had learned to take his advantage in any possible way, probably even by selling himself for homosexual purposes.

Physically, the boy was small for his age and exceedingly fat, suggesting some hormonal dysharmony. During the one consultation for which he was brought, he tried to put up an innocent, harmless facade, obviously lying quite shamelessly. He maintained that the "bad habits" to which his sister had referred, only concerned his interest in "playing". According to him, the family were forcing him to study all day and not giving him any time to play ! He was very evasive in answer to our questions about any possible habits of masturbation, and he also tried to deny his association with friends who had introduced him to smoking, drinking and gambling.

In the few tests which we made the boy do, we noted that he had absolutely no ability to undertake anything on his own, but could only succeed in automatically copying a model. In his love of comfort, he apparently had never learned to use any resourcefulness and inventiveness, but was used to function only with plenty of material provided.

Though, except for the truancy, the lying and occasional aggressive reactions, no definite criminal act, like e.g. stealing or sexual misdemeanour was known of, the boy definitely gave the impression of being utterly corrupted in every respect. His sister, on our suggestion, made an effort at interesting some of the other family-members in the possibility of helping the boy. But she only reported one day, quite discouraged, that no one at home had thought it necessary to undertake anything in the matter.

A good deal of pampering still formed one aspect of the inconsistent parental attitude in the following case :

- (149) *Vinod*, youngest son of a well -to-do lawyer in a small town of U.P., Hindu, *Kayasth*, might at first sight have impressed one as mentally deficient, if one heard that, at the age of 12, he had only reached 3rd class in school. But his lack

of interest and refusal to learn only concerned what was his duty. He seemed to have plenty of alertness, where pleasure was concerned, and he had even tried to drive a car.

While developing normally in other respects, he had started talking rather late. When forced to study, either in school or by a tutor, he had soon learned how to discourage his teachers and guardians by pretending inability to grasp or by using all sorts of other tricks to deceive them about his actual intelligence. The time he gained by either missing classes or getting round his home-work, was spent in roaming about, stealing money, buying toys and playing the generous friend to his comrades. If any of his wishes were refused, he went into severe temper-tantrums, in which he tore and broke, whatever he could get hold of.

While the father still managed to enforce some discipline by his strictness and fits of anger, the mother, a hardworking, compulsively orthodox woman of 46, apparently was completely devoted to this youngest son who again, as in the previous example, had to console her for the death of 3 other sons. When brought for examination, he obviously was out to gain our sympathy by pretending to weep. He stood in the play-room, turning his back, without taking an interest in the toys laid out for him. Next day, after first fiddling with the key of the door, he condescended to take an interest in some playful tests. Even then, however, he took no trouble to perform the tasks properly, but just used the material in his own random manner. It was quite obvious that his failure to solve the tests was not a consequence of any lack of intelligence, but a deliberate attempt to deceive us and, at the same time, a demonstration of his unwillingness to adapt himself to any given conditions. When he was left alone in the play-room for a few minutes, he quickly took some chalk, drew lines on chairs, doors and walls and then gave the chalk to some other child sitting in the waiting-room, so that this little patient should be blamed for the mischief !.

One may doubt, whether one should still call a boy of this kind neurotic or whether his obvious autism might not already justify the diagnosis of a psychotic development. In either case, adequate treatment would have been urgently needed. We were, however, not given a chance for more than prescribing a drug and for giving some advice to the family.

Excessive expectations rather than pampering formed the counterpart of impatience, neglect and irritable scenes in the inconsistent attitudes to which a further boy was exposed :

- (150) *Mushtaq*, a Muslim boy, son of a jeweller, was brought at the age of 15, because, for the last 2 years, he had been stealing and selling things, spending money on cinema and cigarettes, staying away from home late and telling lies about the way he spent his time. He kept bad company with rickshaw-wallahs and doubtful characters in the Mohalla. He just was out to have a good time, eat well,

sleep long and enjoy himself. When at home, he quarrelled with his siblings. Whenever checked about his objectionable behaviour, he would first deny everything and only admit his sins after a good beating.

On hearing this account, one might have expected to find a tough, ruthless young daredevil. Our patient, however, was a delicate, sensitive boy, who had been appreciated by his parents as a quiet, obedient child, up to the age of 13.

He was the 6th of 9 children. Four of the elder siblings were sisters, one of them already married, the other 3 still in the family. The youngest child, aged 2, was also a sister. Two brothers were younger, one elder than the patient. This elder brother, 24 at the time of Mushtaq's consultation, had also gone through a phase of rebellion during puberty age. Later he worked, but spent most of his money on himself, going to the cinema and wearing smart clothes. The father, aged already 60, was hardworking and at times had fits of anger. But on the whole he was fairly understanding and also showed himself open to our explanations and advice. The mother, an intelligent woman who taught her children at home, as she could not bear leaving them in other people's hands, was inconsistent in her attitude : at times she could be quite lenient, then suddenly strict again. She was particularly keen on truth and frankness and resented that this son of hers had even taken to telling lies.

From Mushtaq himself, who first showed himself gloomy and angry, but later opened up, when he realized our true concern, we heard the following story of frustration, resentment and despair :

Since the age of 11, he had had to help at the father's jewelry shop. He had to work from 6 a.m. to 8 p.m., but only was given 4 annas' pocket money daily, which he had to hand over to his mother. Though he had to work like a grown-up man, his elder sisters still expected him to take his share in house work like a child with no other responsibilities. They refused to make his bed and to attend to his clothes and, when he tried to insist on his rights, the matter would end up in awkward quarrels. It seemed quite generally that the women ruled the household. Though Mushtaq considered his father as his best friend, he resented that he did not have the courage to stand up against his wife and daughters. He would have preferred to work under a master who was not at the same time his own father. Possibly he felt that, with the hen-pecked father and the extravagant elder brother, he had no proper masculine model in the family, according to which he could have formed his own inward moral authority at this age.

He told quite openly that at times he used to run away from home in anger, because he was fed up with the eternal quarrels and disputes. He knew quite well that it was wrong to take money. But at such moments he felt so angry that he wanted to cause some damage to the family. At heart, he wanted his

father's welfare and often felt sorry and guilty for his unruly behaviour. It seemed that this boy's whole life was claimed by the family and that his escapades corresponded to a quite legitimate need for growing beyond this narrow frame into a wider world. Unless this need could be recognized, perhaps by sending him for regular apprenticeship or work with a master outside home, or at least by allowing him some recreation on his own, he risked to follow the example of the elder brother who, at 24, seemed to compensate himself for his restricted childhood by ruthless selfishness.

This boy only came for one consultation. But it was quite likely that the father, who showed true concern, might have grasped something of our advice. The question only was, whether he would have the courage to enforce any changes in the regime against the will of wife and daughters !

A similar story, but characterized more definitely by parental neglect, was given by another Muslim adolescent :

- (151) *Ikram*, aged 13, son of a businessman, was brought by his parents on advice of one of our former patients, because, for the past 3 years, he could not concentrate on his studies, at times ran away from school, stole money for going to the cinema and, at times, had violent fits of temper, throwing things. The boy himself first only complained about "loss of memory", but later admitted that, whenever he saw money, he just could not resist. While taking it, he would feel some strange nervousness and excitement, accompanied by palpitations. Next day he usually felt bad about it, cried and apologized.

Ikram was the 5th child, the third boy, amongst 12 siblings. Only one brother, 2 years younger, died at the age of 4. All other children, between the ages of 1 and 22 years, were living and healthy. This already large family was incorporated into the still bigger unit of the joint family of 3 brothers, of whom *Ikram's* father was the youngest. The 3 brothers did not seem to keep equal standards in bringing up their children. A cousin-brother of the same age as *Ikram*, was allowed to go to the cinema as often as he liked, got plenty of money and was never scolded. He had tried to tempt *Ikram* into bad habits. So he too wanted to go to the cinema daily, fly kites and eat "chat" to his heart's content. Furthermore, the wife of the father's eldest brother was domineering, aggressive and quarreling a lot. *Ikram* seemed to be rather more sensitive than the other children and resented the restless, overcrowded atmosphere at home.

The father was usually good-natured, but could go into severe fits of temper. In one of them, he once threatened to throw the patient out of the house. The mother was mentally dull and limited and worried a lot about all her duties in this big family. Between the hot-tempered father and the feeble-minded mother, and with numerous siblings competing for the parents' attention, the sensitive boy had never experienced much care and understanding.

Already sickly in his infancy, he suffered a further setback in health at the age of 10, when he had typhoid. His parents had the impression that he had changed since then : while formerly he had been the most obedient and helpful child in the family, he began to rebel and to have fits of temper after this illness. Up to 4th class, he was a fairly good student. Since typhoid, he had slackened in his studies and was often embarrassed by having his elder brothers pointed out as better examples. In spite of his difficulties in concentrating, the family decided to send him to Arabic school after his passing 6th class, so as to prepare him for the profession of a maulvi. While first it seemed, as if the boy himself were also taking a certain pride in this noble calling, he later admitted that he resented having to go into this priest's training and that he would have preferred to lead a comfortable life, just sitting in father's shop, having nice clothes and going to an English school.

When we examined the boy, depression, a certain restlessness and a cautious self-critical attitude were the most prominent features. He was aware of his delinquent behaviour and himself puzzled about his inability to resist the temptation of stealing money. In projective tests, the predominant mood again seemed to be one of depression ; but we also found the theme of guilt and need for punishment, a sense of restriction and frustration and tendencies to break through all this into phantasies of killing and robbing. In his dreams, he was threatened by a thief who came into the house.

Though the family had little understanding for the child's need, they at least agreed to send him for treatment. Ikram came for psychotherapeutic interviews once a week during 2 months and seemed to profit. Later we did not hear of him again.

Fairly undisguised rejection, though coupled with good material care, seemed to be the lot of only one boy amongst the young delinquents from the neurotic group :

- (152) *Mahesh*, aged 13, is one of the few young patients in our group who was allowed to receive the benefits of prolonged psychotherapy. For a period of one month, he was seen 3-5 times a week by a psychologist. In addition, his mother paid frequent visits to the social worker, at times also to the psychiatrist, and, to help the boy to spend his time usefully while he was staying away from his boarding-school, he was given special tuition and encouragement for games and other recreational activities by a psychologically interested tutor. Consequently, we did not only have a chance of helping this boy more than others, but we were also able to gather more detailed information about him and about the factors that had led to his distorted behaviour.

Mahesh was the first son of a mixed love-marriage between a Hindu father and a Christian mother. His father, aged 40, employed in a well-paid technical job, was

a high-strung, reserved, nervous and impatient man. He was taking alcohol fairly regularly. His horoscope forecast his death at 42, and he seemed to be out to make the best of his life while it lasted. The mother, aged 35, called herself extraverted and optimistic, but at times beset by depressions. Later, when revealing more and more of her life during the interviews devoted to her problems, she had to admit that she was very irritable, self-willed and bad-tempered. She was on one hand overprotective of her 3 sons ; on the other hand she could not show them any emotional warmth and tenderness. In her own adolescence, she used to tell phantasy lies. In her adult age, she found it very difficult to use her imagination, at least when it came to putting herself in someone else's place. She resented the money her husband had to give to his own family. Having been emotionally neglected by her own parents, who, according to her, "had no place" for their children in a busy social life, she had hoped to find emotional stability in a love-marriage, but only to find herself deserted not only by her own family, but also by the in-laws and left to the mercies of a nervous, impatient husband. The only good she could see in having children was, in her own words, "that they made the marriage last."

She had "wanted" the patient, her first son, for conventional reasons, but only "enjoyed" him as long as he was small. Later she found no sense in what he talked and paid no attention. She never seems to have made any attempt at entering into the child's private world and language ; she was, in fact, quite surprised, when, under our guidance, she gradually learned, how little she had been aware of her son's rich inward world. Her selfish interest in the boy further had slackened, when he developed some deformities of teeth and bones, probably due to early rickets. When two healthier, "smarter" boys were born, she concentrated, whatever affection and attention she had, on these two. When, in more recent years, Mahesh had begun to develop increasing lack of concentration, irritability, rudeness and restlessness and a habit of telling lies and at times even taking small sums of money, she more and more began to regard him as a "real monster". At times she lost her temper on him and beat him. At a moment like this, the boy once warned her : "If you do this again, I will kill you." Reproachfully she told us, that the boy resented her "social life", which of course she could not give up for the children's sake, even while they were at home for holidays from boarding-school for a short time. Altogether, one got the impression that the mother was a thoroughly selfish, immature woman, who had no sense for the needs of others and no way of expressing any tender emotions. One felt no surprise at all that the boy strongly rebelled not only against her, but also against his younger brothers who had taken away whatever little affection he had enjoyed at least during the first 3 years of his life.

With thick glasses for high myopia, his teeth in braces, knock-kneed and bow-legged and with the awkward proportions of early puberty, the boy certainly did not look too attractive. But when he warmed up a bit, already during a first interview,

it was quite easy to feel sympathy and interest for him, as he proved to be affectionate, friendly and, in contrast to his mother !—very sensitive to other people's needs. One day, for instance, he was quite embarrassed and guilty about keeping the doctor a few minutes beyond the ringing of a bell which, as he found out afterwards, was the signal for lunch-time. He showed himself very grateful for any little sign of concern and affection. When later, however, he realized that in his regular psychotherapy hours he was not just expected to be on his best behaviour, but meant to have a real play-ground for expressing even his worst tendencies, he became rather trying : missing his interviews, attempting to shift the time for them to suit his convenience, at times by telephones in a changed voice, pretending that he was some relative ; telling lies ; taking away pencils and other things from the therapist's room ; in short : testing out the therapist's patience and affection, as one is used to expect it in "abandoned" children who have lost confidence in anyone's love and concern. In projective tests, the main tendencies observed were depression, resentment against criticism, aggression, particularly against his mother, a tendency to withdraw into a solitary life. A few weeks of treatment were of course not sufficient to undo the harm of years of neglect and insecurity. When it was time for school again, the boy at least was allowed to rejoin his old boarding -school, where previously, due to his awkward and rude quarrelling with other boys, his further career had been seriously in doubt.

About 3 years after this short phase of treatment, we were asked for a medical report about our observations, as the boy was about to be sent to a special school for maladjusted adolescents in England.

The case of the one girl who was a victim of parental rejection, *Kamal Kaur*, (82), who had run away from home dozens of times before she was brought for consultation and who, on or before these escapades, used to steal food and money, has already been given in the chapter on neurosis.

(b) *Potential Delinquents*.—One almost hesitates to use the term "potentially delinquent" for a small group in which the patients show even less of delinquent behaviour than the cases already summed up. If one applies the term "delinquent", as some authors would, only to cases whose misbehaviour has brought them into contact with police and judiciary authorities, none even of the children presented up to now would really deserve this label, and we might have to call *them* potential delinquents, "actualisation" then depending on the chances of carrying the delinquent tendencies into situations outside the home, and furthermore, on the vigilance of the authorities. In a wider sense, however, the cases already presented certainly can be regarded as "delinquent", *i.e.* as having left the path of well-ordered, lawful behaviour. One will see that, in the group to be discussed now, the delinquent tendencies have not come out into the open so distinctly yet.

As already mentioned earlier, this small group on one hand illustrates predelinquent situations in which inner tension may not be particularly great, but in which the control of consciousness over any repressed tendencies is deficient, as *e.g.* in epileptics. On the other hand, we have included a few cases in which, as yet, conscious control is intact or even excessively tightened, but in which antisocial tendencies seem to ferment underneath this pressure to a degree that might possibly result in their sudden breaking through into action.

We start with the first mentioned cases, all boys with epileptic manifestations :

The history of *Balram* (54) has already been summed up in the chapter on epilepsy.

- (153) *Ramesh*, an 11 year old Hindu of scheduled caste, had been sickly since early infancy. Epileptic fits were noted since the age of 8, and his intelligence, already poor before, had since deteriorated more and more. By the time he was brought for consultation, he had become quite forgetful, stubborn, short-tempered, restless, abusive and destructive. He often ran away from home and roamed about. When obstructed, he would beat and destroy things. He only ate little at home, but wanted to buy nice things outside.

In spite of his epileptic dementia, the boy still looked quite alert and mischievous. While watching him in play and during tests, we got the impression that he was not quite as unintelligent as it appeared. He had learned to hide his abilities, possibly so as to have a convenient reason for escaping from work and for being excused for his mischief.

This boy certainly had a basic antisocial attitude and, as at the same time his consciousness at times got disturbed by epileptic manifestations, he seemed to be highly predisposed to delinquent behaviour. His parents, a rather dull, short-tempered father, employed in railway workshops, and an equally short-tempered mother, who probably had pampered the boy as the first and only surviving son, did not seem to be able to exercise any effective control over him.

We prescribed some antiepileptic medicine, but were never informed about the result.

A last case from the epileptic group, *Edward* (60), has already been summed up earlier. One may remember that this elder son of a working mother had fits of probably focal epilepsy. His mother considered him as a "badmash", because he at times stayed away from school and occasionally threatened with violence. Though, apart from the truancy and the lies he told about his roaming about, and his occasional threats, he had not committed any delinquent act, aggression and resentment, which even in his "normal state" he could hardly suppress sufficiently, might easily have burst into a dangerous demonstration during a phase of altered consciousness.

A similar combination of accumulated aggression and lack of conscious control, this time, however, not of epileptic type, but probably of a more hysterical character, has been demonstrated earlier in the case-history of *Amir* (96).

In his fits, he used to scold and abuse and even in his phantasies in waking state, in answer to our questions and the tests presented to him, aggression played a quite powerful role. His picture-stories betrayed his need for a further period in the shelter of the parental home in the village, and the overanxious mother was only all too ready to give in to this wish.

It seems indeed that removal from the security of home environment or even only separation from a figure of authority, as e.g. a father, at an age when inward moral control is only just starting to establish itself, were amongst the factors that can seriously upset the delicate balance between conscience and aggressive forces in a young adolescent. Two cases in which conflicts of this kind were particularly obvious, have already been quoted at length : one *Vimal* (100), who was shocked by the thoughts of rebellion against authority that rose within him and who invested his growing tension in a whole variety of symptoms, and *Rehman* (76) who developed compulsive fears of killing someone after his father had been transferred to a different city and he had to take over more responsibilities at home.

While, in these two cases, the aggressive tension had come fairly close to the surface, frightening the boys and driving them into all kinds of pathological defences, our last case, a girl, is one in which the delinquent tendencies are only very faintly indicated :

(154) *Rajrani*, aged 13, was the pampered only daughter of a Hindu merchant. She had 3 brothers, two younger and one elder. Her mother, on one hand, had high expectations that this only daughter of hers should reach all the ambitions which, due to an early marriage, she herself had not been able to fulfil, namely higher studies, accomplishment in dancing, music and all other arts that might render a young girl perfect. On the other hand, neither she herself nor anyone else in the family was giving any example of hard work, as there were plenty of servants and everyone had become lazy and complacent. In this atmosphere, *Rajrani* too, though she had some perfectionist ideals, had settled down into a life of comfort and little exertion. For school, where she had advanced fairly steadily, she only learned when pressed by her tutor. She never bothered to take interest in housework, as the servants had everything well in hand. As to her wishes, they always were fulfilled without any difficulty. She avoided any actual effort and had become accustomed to live in an easy phantasy world, if not her own, then that of novels and cinema.

The family doctor advised the parents to take her to the Psychiatric Center, as her lack of interest and initiative had begun to impress them as abnormal and as, furthermore, she at times had spells of sleepwalking.

Our two interviews with the plump, fat young girl showed that the complacent, dull surface was covering up quite a bit of tension. Her nails were bitten, she could not settle down in a chair comfortably, but kept nervously sitting on the edge. First, she would not even speak, but only covered up her embarrassment by constantly fiddling with her clothes or hair. More than just lazy and dull, she seemed to be sulky and spiteful. One got the impression that she was "on strike". She finally admitted this, but did not even know herself, what she was striking for. One feature seemed to be that, similar to her mother, she had some high perfectionist ideals. Rather than do a thing imperfectly, she would not do it at all. And as perfection requires effort and energy, she had condemned herself to a life of stubborn resignation. Another factor in producing this deadlock may have been that, as all her wishes were automatically fulfilled, she simply had no opportunity for ventilating the spirit of rebellion, which is a quite normal and customary feature in this first phase of puberty.

One of our adult patients, who had grown up in a similar situation of comfort and immediately fulfilled wishes, told us how, one day at puberty age, he stole some money from his father's cash-box and bought a fountain-pen, just because for once he wanted to get something in an adventurous way instead of obtaining it by the usual easy route. In his later life, this same patient committed several offences, possibly out of this same spirit of adventure, which in his all too smooth life found no outlet.

That in Rajrani the rebellious tendencies were present, was promptly demonstrated in the projective tests. The girl's stories were full of crime phantasies, which betrayed a quite amazing knowledge of the underworld of murder, robbery and prostitution. Her sleepwalking, about which unfortunately we could not get much information, seemed to indicate that a drive for action, which in waking life found no outlet, was trying to make use of a state of reduced consciousness. At the moment when we examined Rajrani, the thick padding of lethargy, spite and resignation seemed to be sufficient to hold down any delinquent tendencies; but it was at the same time also stifling any other interest and initiative. We had no chance of trying to loosen this defensive armour. The girl, living in a country-town of U.P. far away from Lucknow, was not brought back after the first 2 consultations.

These last 3 case-histories, more perhaps than the others, demonstrate very instructively, how important it is for young people to have an opportunity for resisting and for bearing obstruction, a chance for measuring their strength and courage and at the same time for "letting off steam" in some adventurous situation. While, in childhood, excessive parental care or even pampering may spare them obstacles and frustrations, they will not get round the necessity of facing the own inward obstacles which, at the time of puberty, in the form of aggressive urges and vague sexual sensations will rise. High moral ideals, as long as they are only taken over undigested, simply copied from the surroundings, are no protection against these new threats. On

the contrary : the more the moral concepts have been rigid and perfectionist, the greater will be the shock and anxiety provoked by having to confront the shadows within.

Coming from the West, where the process of teaching children discipline and ability to bear frustration is started already in infancy, one is amazed to see, how "permissive" the attitude of most Indian parents is. One gets, however, as already mentioned earlier, the impression that this tolerance for mischief and the corresponding eagerness to fulfil every wish does not stem from genuine kindness and from true concern for the child's ultimate welfare, but rather from the parents' own anxiety and their inability to bear with the child's resistance and anger. In reaction to this, many children learn to manipulate and even to tyrannize adults in the family very cleverly and, by the time the more powerful resources of an adolescent are at their disposition, the parents may find themselves in a position in which their offspring have become utterly unmanageable. Finding no support in their elders in resisting the rising forces within, the young people in their turn are beset by anxiety, a vague sense of being threatened. This again can lead to further attempts at "acting out" in an antisocial manner. That nowadays these reactions no longer remain confined within the family, but lead out into public life, has been sufficiently demonstrated in recent years by the many student riots and the arrogant behaviour of young people with regard to their "rights," for instance in public means of transport.

For some children and adolescents, at least tackling the programme of studies in school presents an obstacle on which they can harden their courage and determination. For those who are gifted with quick grasping power and a good memory, or, on the other hand for those who attach no importance to scholastic merits, even studies do not offer a sufficient resistance. In this respect, sports, games, camps ; voluntary activities in farming, flood relief or other opportunities for physical exercise in service for others, if possible with a tinge of the adventurous, fill a very important place in preserving and improving the mental health of our young people. In examining the interests and hobbies of the 22 children presented in this chapter, we found that, amongst the delinquent children, interests of a purely passive kind were much more frequent than the more active ones, while the potentially delinquent children seemed to engage not only in more active, but also in more organized ways of passing their time.

From this, as from many others of our observations, one will have to conclude that, preventing juvenile delinquency may not only mean relieving economic misery, precarious social situations and avoiding frustration, but, on the contrary, also getting young people used to healthy exercise and directed activity, to bear strain, obstruction and resistance, so that they may learn true self-control.

CHAPTER V

Conclusion

After devoting numerous pages of text and a whole collection of Tables and Graphs to the relatively small number of 208 Indian children observed at a private Psychiatric Center in Lucknow from 1956 to 1961, we have to ask, what insights have been gained and what conclusions can be drawn.

If we consider mere facts and figures, the result of our investigations can be summed up as follows :

General Remarks.—Not only our own experiences, but also those made at other child guidance clinics, suggest that Indian parents are becoming aware of problems and difficulties in bringing up their children. They also begin to realize that modern psychiatry and psychology can offer help. Often, however, they make use of already existing services very tentatively, with unreasonable expectations of a magic cure and with little understanding for the necessity of prolonged observation and treatment. While other, more official services already seem to enjoy the cooperation of children's hospitals, schools, child welfare agencies and juvenile courts, our own material consists mostly of cases brought by the parents themselves. In particular, we note a remarkable lack of cases referred by teachers !

The present-day emphasis laid on literacy and higher education, throws into the foreground all defects and disturbances which impair intellectual capacity. One therefore finds, amongst the patients of child guidance clinics, a great proportion of mentally deficient, brain-damaged and epileptic children. The more subtle behaviour problems only seem to cause concern in parents of higher social and educational status. Less educated and socially developed classes only appear to be stirred into seeking help by gross disturbances, such as psychotic manifestations, acute anxiety attacks and mental impairment acquired through postnatal illness. Congenital mental deficiency, particularly in its less severe degrees, still seems to be tolerated in illiterate or little educated families, while epilepsy, particularly in rural surroundings, continues to be regarded as a sign of possession by evil spirits and therefore as an object for indigenous methods of exorcism rather than for modern medical care. The further spread of education, however, will probably render more parents aware of the nature

and importance of such defects, and claims for suitable educational and occupational facilities for mentally handicapped children are to be expected.

Not only our own material, but also figures for other child guidance clinics (Delhi, Bombay), seem to indicate that psychotic manifestations or autistic development in children have been observed more frequently during the last few years. This may correspond to an actual increase in such disturbances, possibly in connection with the present changes in the social structure of the country ; it could, however, merely mean that certain types of parents are becoming more sensitive to distortions of development in their children or that a particular way of life, previously sheltered in the empathic-symbiotic climate of the joint family, is exposed as inadequate in the modern type of individualistic, competitive society.

Other phenomena too, *e.g.* the considerable number of neurotic children of all ages and of psychotic adolescents who have enjoyed relatively good parental care, the nature and often sudden onset of their symptoms, make one suspect that the emergence from a sheltered, congenial or so-to-speak "homeoplastic" environment into a wider, more demanding world, which presupposes an ability to face and digest what is "different", "foreign", may be an important factor in leading to emotional disturbances.

Certain features of the old order, however, as *e.g.* early marriage, seclusion in purdah for adolescent girls, also seem to claim their victims, though perhaps again only in contrast with the new order which holds up alternatives, where, previously, conditions of life were unquestioned.

Amongst the various factors discussed for each diagnostic category, the following seem to have particular relevance :

Distribution according to sex.—Not only our own figures, but also the statistics of other child guidance clinics, indicate a distinct predominance of male children amongst the patients. The ratio, however, varied between the different diagnostic categories and also between different age groups. In our material, the proportion of girls comes closer to that of boys amongst the cases with functional disturbances, and even exceeds the boys in the group of psychotic adolescents. There is reason to suspect that this ratio, at least amongst the congenital-organic groups, is due to social rather than to biological factors.

Distribution according to age.— The distribution according to age, in most groups, seems to indicate that the time of consultation is not always a function of the onset of the illness, but rather of some purposefully timed intention to make the child fit, either for entering school or, at puberty age, for marriage, higher education or a career. Investigations about the time of onset and the duration of symptoms before first consultation in the functional groups, show that acute manifestations which either greatly

alarm the relatives or cause severe suffering to the patient himself, may determine search for immediate help. Cases of this kind are to be found mostly amongst children of the older age groups, in whom the rising sexual and aggressive urges can cause severe upsets.

Reasons for Consultation and Main Symptoms.—That parental concern about intellectual performance and scholastic achievements is a powerful stimulus for seeking consultation, though not always for persisting in treatment, has already been mentioned. A more detailed study of symptoms has been undertaken for the functional groups, and attempts have been made to investigate, whether particular neurotic features have any correlation with environmental factors such as religious community, joint or individual family, position in the sibling-row and parental attitude. Though some influence of such factors on symptom formation seems probable, we have found that one has to be careful not to generalize too much, as a particular condition, *e.g.* position in the sibling-row, may not have the same significance in the constellation of circumstances in each individual case.

A particularly intriguing question is the predominance of certain syndromes and symptoms in one or the other of the main religious communities : Hindu and Muslim. Though certain figures look convincing and though the cultural background suggests arguments apt to explain such differences, investigations on a wider material will be needed to allow any definite conclusions.

Local Origin.—The percentage of children from rural surroundings, especially if we weigh them against the Census figures, is meagre. One should, however, perhaps rather be surprised that any children from villages and small country-towns have found the way to a Psychiatric Center at all, and even more that the greater part of them belong to the functional groups. The greater tolerance for mental defects in a largely illiterate rural population and the superstitious attitude with regard to certain other disturbances, *e.g.* epilepsy, has already been pointed out as a reason for this unexpected distribution.

The fact that a considerable percentage of our small patients were brought from outside Lucknow, signals the necessity of planning children's psychiatric services not only in big cities, but also in smaller towns and rural areas, perhaps through mobile units.

Migration has played a certain role in some of the patients. It seems, however, that a mere shift in local surroundings or even the fate of a refugee, as long as the family itself remains intact and provides emotional shelter, is less likely to affect a child than any drastic change or lack of harmony within the family.

The few foreign children too seem to have been victims less of transplantation into a different cultural setting, than of the instabilities of their parents.

Community and Caste.—The rather striking differences in distribution of Hindu and Muslim patients in various diagnostic categories (large share of Muslims in the neurotic and infantile group, complete absence in the group of infantile psychosis and small share amongst psychotic adolescents) have already been mentioned. Further investigation in this respect might be worthwhile, keeping in mind that any actual differences need not necessarily refer to incidence, but that they might merely indicate a different sensitivity or tolerance for certain phenomena in one community or the other.

Distribution according to Hindu caste, as far as the small figures have any relevance, seems to show a greater concern or perhaps intolerance for children's intellectual and emotional deviations and possibly a greater readiness to spend time, money and interest on consultation, amongst the higher castes. The share of scheduled castes is highest, where the morbid manifestations have very obvious, dramatic character. A somewhat baffling problem is the uneven distribution of Kayasth children, with a predominance in the congenital-organic group.

Occupation of Father or Guardian.—The distribution according to occupational classes shows a picture similar to that in the graphs for the Hindu castes. It is remarkable that children from farms are more frequent in the functional groups. A predominance of fathers from academic professions or high positions in service in the group of infantile psychosis, tends to confirm certain Western theories about the sophisticated, emancipated surroundings in which autistic development is likely to occur. Our material, however, shows that similar features in small children can also originate under quite different conditions.

Joint and Individual Family.—Our information in this respect was not complete. The most relevant findings were made in the group of neurosis, where $\frac{1}{3}$ of the children were known to come from joint families. It looks, however, as if one had to distinguish certain syndromes that are more likely to occur within a still intact joint family and others which, on the contrary, are a reaction to the loss of its shelter. The multiplicity of parent-figures, which other authors have described as an obstacle against distinct ego-formation in the extended family, does not seem to have played so significant a role, except perhaps in one case Shanti (129). It seems to be more the general atmosphere of empathic-symbiotic living that prevents the child from realizing himself as a separate individual. Possibly, certain patterns of behaviour, which the West might consider as deviant, are sheltered and concealed within a joint family and are only "brought out" as inadequate, when this social structure crumbles.

Lack of Parents.—The popular assumption that children who are orphans or half-orphans are more likely to develop emotional disturbances, is confirmed, insofar as relatively more children in the functional group than in the congenital-organic group had lost their parents. Their absolute number, however, except in the group of psychotic adolescents, seems negligible. But one has to remember, as in many other

respects, that our material may not be representative, either numerically or qualitatively, for all children with emotional disturbances, but only for those who still enjoy sufficient parental care and interest to find the way to a psychiatric clinic !

Not only lack of parents through death, but also absence of fathers on out-station duty or of mothers who prefer work and study outside home, play a role in our material. Some of our case-histories make one wonder, whether the loss in human health and happiness through the distorted development of a child is worth the gain in prosperity or prestige which a mother hopes to achieve by "emancipating" herself !

Heredity.—Our figures for heredity, except perhaps for the group of epilepsy, correspond more or less to what one would expect according to text books : highest figures for the 2 psychotic groups and for oligophrenics. Psychiatric morbidity includes more diseases of congenital and organic type in the relatives of children of the congenital-organic groups, while functional disturbances prevail in the families of neurotic and psychotic children. On closer analysis, we found that, in most groups, the figures for psychiatric morbidity in the parents come very close to or even equal the general figures for "heredity". Particularly for the functional groups, this suggests that, what appears as biological transmission of defective genes, may perhaps rather have the character of a postnatal environmental influence. A few of the case-histories quoted are of special interest in this respect, as two or more members of the same family,—either several siblings or one of the parents and a child,—were examined and treated by us.

High figures for early mortality amongst siblings are found in the same groups in which the percentage for "heredity" is considerable ; in addition, however, also in the epileptic group. This makes one suspect that a same fundamental lack of vitality in the child or, expressed otherwise : a same inability to bestow and protect life on the part of the parents, may be responsible for failure to survive the embryonal period or early infancy in some children and for congenital deformations or weakness that predispose to later emotional distortions in other issues of the same family.

Number of Siblings and Position in the Sibling-Row.—Great care has been taken to give solid statistical proof for the vague impression that children who occupy special positions in their families, in particular that of the eldest child, are more likely to develop emotional disturbances. Figures that considerably exceed the rates to be expected, if all positions had been equally exposed to risk of psychiatric illness, are found for "special positions" in the groups of neurosis, adolescent psychosis and epilepsy. In all congenital-organic groups, "special positions" are far more frequent amongst those cases in which the primary congenital or organic disorder was complicated by functional superstructure. This indicates that a mentally handicapped child has more chances of developing harmoniously within his limits, if he is not exposed in a unique position amongst the siblings.

A marked predominance of only sons is found in the group of infantile psychosis ; all girls in the group of infantilism are second daughters, while in the group of psychotic adolescents, eldest daughters take the most prominent place.

Age of the Mother at the Child's Birth.—Mothers younger than 20 years at birth of the child are found most frequently in the groups of epilepsy, oligophrenia and neurosis. While in the two former groups the maternal immaturity may have had its biological consequences (see also the high sibling mortality figures for epilepsy and oligophrenia !), the mothers of the neurotic children may have caused harm through their lack of emotional readiness to care for a child.

Exceptionally old mothers reach a fairly high percentage only in the group of psychotic adolescents. In some individual cases, however, their tendency to cling to a youngest child for their own emotional security and satisfaction, seems to have had disastrous consequences.

Complications of Pregnancy and Delivery are, as one would expect, more frequent in the congenital-organic groups, but also reach a high percentage in the group of infantilism. Better pre-natal and obstetric care may succeed, in future, in reducing the number of children with brain-damage due to intrauterine complications or birth injury.

The Period of Breastfeeding.—The very marked differences, not only in duration, but also in regularity of breastfeeding between India and Western countries, tempted the author into investigating this factor more closely, though information was not as complete as one could have wished. The Western author's initial misconception that lactation beyond one year must be regarded as exceptional, was fortunately corrected by her obtaining some figures for comparison from a maternity clinic, which take 1½—2 years of breastfeeding as a "normal" period. Even then, the figures for breastfeeding beyond the age of 2 years, reach values bigger than the general average in the group of epilepsy and even more amongst the psychotic children. Again, however, one has to judge each case on its own merits. While, in some instances, prolonged breastfeeding no doubt was a sign of an unhealthy maternal attitude, it may perhaps have been almost life-saving, when a child was severely handicapped or immature since birth. Furthermore, the effects of prolonged and unregulated breastfeeding may differ according to the later pattern of life which the child has to face.

In some of the case-histories, particularly in the group of infantile psychosis, there was evidence of harmful effects of all too early or too abrupt weaning.

Toilet Training.—Little information was available about this aspect of child-rearing, in which Indian mothers again tend to be far more permissive than their Western counterparts. The only child who was explicitly brought for bedwetting, was Anglo-Indian. Enuresis was mentioned in some of the other children, but not

as the main symptom. Parents tended to regard it rather as a sign of deficient intelligence than of emotional disturbance.

In the 2 psychotic groups, partly also in neurotic children, loss of control or inhibition with regard to excretory functions was noted in connection with autistic patterns of behaviour.

Early Neglect and Separation.—Some single examples of children who were exposed to early neglect or separation confirm on the whole the observations made in the West. Of several children we knew that they had been unwanted ; some of the mothers had even attempted abortion during pregnancy. After delivery, the rejecting attitude persisted in some cases, while in others it was over-compensated by excessive concern.

Parental Attitudes quite generally seem to have had a very important place in shaping the children's emotional life. In the congenital-organic groups, nearly all the children who developed functional complications were exposed to harmful parental attitudes. While in the groups of neurotic children and psychotic adolescents, one is surprised to find relatively many children who enjoyed fairly normal parental acceptance, none of the children in the group of infantile psychosis were thus favoured. Amongst the children who presented delinquent features, only the small sub-group which we considered as "potentially delinquent", includes children whose parents showed normal concern.

The possible significance of the "accepting" parents in the group of neurosis and adolescent psychosis has already been pointed out : it may be that it is the loss of this relative shelter, the contrast on emergence into a more individualistic and competitive society that causes the breakdown, and not the family atmosphere as such.

Physical Defects.—Physical defects in form of organic brain-damage or congenital malformations are naturally more frequent in the congenital-organic groups than in the functional section. Their discrete presence, however, in quite a number of the emotionally disturbed children, caused us to reflect, in which way such physical deficiencies might expose a child to distortions in his development. This question has been specially investigated for the group of infantile psychosis, where constitutional and environmental factors seem to have had a particularly obvious and varying interaction.

The role of acute physical illness, possibly associated with fear of death and threat of permanent disability, in precipitating emotional disturbances, has been demonstrated on some of the cases of the neurotic group.

Former Illnesses.—An attempt has been made to compile statistics on several infectious or dystrophic illnesses through which the children had passed. The effect of typhoid, possibly also small-pox, on resistance of the nervous system, and a

possible connection of infantile liver cirrhosis with later deviations in emotional development, might be worth investigating in greater numbers of children, perhaps starting from a "population" of patients presenting the physical illness and comparing it with the incidence of emotional disorders in children who have not passed through the diseases in question.

The relative freedom from infectious illnesses in the 2 groups which only contain children of the lower age-groups, may indicate that the beneficial effect of better prophylaxis and treatment facilities developed in recent years is beginning to make itself felt.

One has, however, to remember, in reading these figures, that the frequency with which some physical illness occurs in any diagnostic group, may not necessarily be a function of actual incidence, but possibly of survival !

Education.—The educational standard achieved by the children in our material, varies with the diagnostic groups. The figures for the congenital-organic groups reveal the lack of adequate facilities for teaching and training mentally handicapped children by special methods.

Amongst the neurotic children, we find some who had become the victims of their parents' excessive demands or their own unreasonable ambitions to shine with intellectual achievements. In the group of psychotic adolescents, we find that the small number of boys were all engaged in higher education, while the girls had had little schooling.

Problems of Adolescence played a role in those groups which contain patients of all age-classes. In some cases, they were the consequences of the intrinsic biological and psychological transformations that occur at the time of puberty ; in others, the changes in life dictated by social custom, such as early marriage, seclusion in purdah for girls, early engagement in work and adult responsibilities for boys, seem to have precipitated morbid phenomena. Examples of neurotic reactions, psychotic breakdown and delinquent behaviour in adolescents of both sexes give an instructive picture of the hazards at this decisive age of emerging into individual discrimination and responsibility, and of the need for proper guidance.

Children's Interests.—Information in this respect is incomplete. The limited data available can give some indication, in what areas educational attempts could possibly take their start in mentally handicapped children and what spheres of recreational activity ought to be encouraged for children and adolescents in general, so as to promote the ideals of mental health.

Number of visits and Possibilities of Treatments.—As we have already mentioned in the beginning of this summary, few parents had the necessary understanding and persistence to cooperate in prolonged treatment and, in particular, to face their own

shortcomings. With the available methods of drug treatment, psychotherapy, occupational therapy and parent guidance, more children could have profited, if their visits had been continued beyond the initial stage.

Along with the further development of psychiatric services for children, a great deal of effort will have to be spent on disseminating appropriate information about their aims and possibilities amongst parents, teachers, doctors, social workers and others concerned with child welfare.

So far our findings, extracted in the form of sober facts and figures from the wealth of human experience contained in all the case-histories. One will, however, have noted that, in many places, the author has not limited herself to stating the objective results of her investigations, but that she had tried to give explanations of a somewhat unusual kind, often formulated in rather sketchy, perhaps "unscientific" language.

If a Western psychiatrist observes and treats Indian patients, his way of looking at life will reveal the patient to himself in new, unfamiliar aspects ; at the same time, if the psychiatrist makes an honest attempt at keeping himself open to the phenomena that are unusual to him, he can hardly avoid revising and adjusting some of his own views and attitudes. Many of the commentaries, interpretations and suggestions which the author has dared to offer in this book, are the result of such cross-cultural experience, which, though it may have been able to draw from the literature of both, East and West, yet has to find its own, new expression.

The author can only hope that these perhaps unorthodox additions, tinged by personal insight and reflection, may succeed in bringing some of the discoveries of Western psychiatry and psychology closer to the wisdom of traditional Indian thinking. For the Indian reader, this approach may help to move mere theoretical knowledge out of its isolated compartments, allowing it to penetrate the whole person and to open up understanding for the psychosomatic wholeness and the total needs of the children to be cared for. The Western reader, on the other hand, may find his horizon widened in other respects. He may for instance have to discard his concept of man as a primarily closed unit facing a separate, objective world, and his almost magic belief that any fact discovered by the so-called "basic sciences" really provides a "basic" understanding for the phenomena observed.

Finally, it may be fitting to say a word about the title which has been chosen for this book : "Indian Children on a Psychiatrist's Playground." When the author asked one of her European friends and colleagues for his opinion about it, the reply was a sceptical warning : "It might be misunderstood. The Indian people, who are so sensitive about a foreigner's reaction to them, might regard it as lacking in respect and seriousness. It may suggest to them that the psychiatrist considers their children as mere toys with which he passes his time."

Whoever may have entertained such doubts about the meaning of the title, will by now, after having read the various references to the “playground of therapy” in the text, have realized that this term, already used by Freud, certainly does not intend to designate a place for the psychiatrist’s amusement. It refers to the sphere of freedom and permissiveness, which the psychotherapist keeps open for his patients, so that, in its light and shelter, they may discover their potentials and try out their possibilities.

It may be significant that it was a European psychiatrist,—*i.e.* a man who daily witnesses the ravages which the Western spirit of technical efficiency and economic usefulness works in his patients,—in whom the title of this book provoked these doubts and suspicions : the idea that the psychiatrist might be accused of “making use” of his patients for his own pleasure ! Most of the author’s Indian friends, possibly still familiar with the idea that this world itself is the “play of Maya”, were quick to grasp the promising challenge which this “playground” holds out : To be allowed to be a carefree child or even to become one again, if one has already passed beyond childhood, to forget about the seriousness and purposeful rigidity of daily life and just to give one’s imagination free course ; to test out one’s strength, one’s talents ; to gain confidence by learning, in all the variations of creative, playful invention, that experience need not always repeat itself in a compulsively fixed sequence, but that there are degrees of freedom in thought, action and emotional participation ; to discover that one does not always have to be shaped by circumstances, but that one also has the power to transform the world ; above all, to find a place which, just as an ideal playground, provides not only sufficient space, but also shelter against harmful influences.

At a time, when rapid social and cultural change on one hand break up secure old patterns of living, while, on the other hand, new possibilities of development are thrown open, but also new responsibilities imposed, such playgrounds are needed more than ever. Playgrounds not only in the literal sense, as islands of safety and freedom for the children threatened by the turmoil of modern cities, but also, as our title indicates it, in the form of the truly human care and concern of those who are entrusted with helping India’s children to grow into “The Future of the Nation.”

INDEX OF CASE HISTORIES QUOTED

Of the page numbers, the first, *Italicised*, indicates the page on which the case history is quoted in full ; the remaining numbers refer to the pages on which further mention is made.

1. Oligophrenia

1. Rani, 85.
2. Aslam, 85.
3. Pushpa, 86.
4. Shankar, 88, 109.
5. Sharda Devi, 88.
6. John, 89, 104, 107.
7. Ashok, 89.
8. Kishore, 89.
9. Malti Lal, 90, 104.
10. Neerja, 91, 92.
11. Shant, 91.
12. Laxman, 92.
13. Gudu, 93.
14. Subhash, 93.
15. Zamir, 97.
16. Nirdosh, 98.
17. Subodh, 98.
18. Ramchandra, 99.
19. Parshottam, 103, 105, 109, 110.
20. Vijya, 106.
21. Ramkrishan, 106.
22. Asha, 106, 122.
23. Hasan, 109.
24. Anand, 110, 120.
25. Mohan, 113.
26. Sarala, 113.
27. Victor, 114.
28. Arfa, 115.
29. Baleshwar, 116.
30. Adarsh, 117.
31. Sukhdev, 118.
32. Sudhir, 119.
33. Mangalawati, 123.

2. Postencephalitic States

34. Girish, 129.
35. Jehan, 129, 136, 145.
36. Pappu, 129.
37. Ahmed, 130.
38. Rameshwar, 130, 138.
39. Gopal, 131, 132, 138.
40. Pratap, 131.
41. Krishan, 132.
42. Jai Raj, 134, 138.
43. Vishvanath, 135.
44. Naheed, 136.
45. Masih, 136.
46. Sheila, 137.
47. Kiran Bala, 138.
48. Ranjit, 139, 144.
49. Joya, 141.

3. Epilepsy

50. Ram, 155.
51. Maya, 156, 162, 166, 167, 170.
52. Ismail, 157, 163, 167.
53. Suman, 158, 167, 170.
54. Balram, 159, 162, 170, 464.
55. Hilal, 162, 166, 167, 170.
56. Radha, 163, 164, 167.
57. Sarju, 164, 166, 168.
58. Prem Prakash, 165, 166, 167.
59. Farida, 168, 169.
60. Edward, 170, 173, 447, 464.

4. Organic

61. Vinai, 174.
62. Arun, 174.

- 63. Walter, 175.
- 64. Avinash, 176.
- 65. Pamela, 177.

5. Neurosis

- 66. Sohan, 198, 211, 242, 282, 287.
- 67. Amrit Kaur, 200, 219, 228, 272.
- 68. Caroline, 201, 228.
- 69. Uma Shankar, 204, 207, 228, 242, 253, 287.
- 70. Promod, 205, 242, 247, 286, 288.
- 71. Iqbal, 207, 211, 228, 237, 245, 266.
- 72. Jagdish, 210, 225, 228, 299.
- 73. Tajwar, 211, 242, 287.
- 74. Shobha, 213, 242, 247, 250.
- 75. Samiun, 215, 218, 228, 243.
- 76. Rehman, 228, 232, 237, 282, 443, 465.
- 77. Kamal Kishore, 231, 237, 242, 255, 258.
- 78. Pradeep, 233, 237, 260, 276.
- 79. Veena, 239, 242, 247, 253, 258, 274, 277.
- 80. Vijay, 244, 252, 254.
- 81. Anil, 247, 255, 258, 278, 282, 286.
- 82. Kamal Kaur, 249, 463.
- 83. Premi, 251, 282.
- 84. Motilal, 253.
- 85. Kenneth, 256, 287.
- 86. Rita, 259, 262, 274, 361, 453.
- 87. Naseem, 261, 272.
- 88. Nazar, 267.
- 89. Ajit, 269, 286.
- 90. Fatima, 270, 385, 393.
- 91. Sudha, 271, 287, 288.
- 92. Farzana, 273, 276, 287.
- 93. Yogendra, 275, 276.
- 94. Kusum, 276.
- 95. Abu, 277, 287.
- 96. Amir, 278, 293, 465.
- 97. Shafiq, 281.
- 98. Ishrat, 281.

- 99. Vivek, 287, 447.

- 100. Vimal, 289, 295, 297, 299, 389, 465.
- 101. Madhu, 293, 299.
- 102. Nur-us-Sah, 298.

6. Infantilism

- 103. Imtiaz, 310, 312, 314, 317.
- 104. Padmini, 312, 314, 316, 317.
- 105. Neeraj, 315, 316, 317.
- 106. Asia, 316, 317.
- 107. Salma, 317.
- 108. Sanjay, 317.

7. Infantile Psychosis

- 109. Jumna Prasad, 332,
- 110. Sajjan, 340, 346, 364, 369.
- 111. Sitaram, 340, 359, 364, 367, 373, 379.
- 112. Prakash, 342, 350, 368, 379.
- 113. Rajendra, 347, 373, 379, 382.
- 114. Meera, 350, 359, 367, 369, 372, 379, 382, 386.
- 115. Ravindra, 351, 358, 364, 365, 372, 379, 382, 383, 392.
- 116. Ranjana, 354, 358, 367, 379.
- 117. Prahlad, 355, 364, 367, 372, 382.
- 118. Virendra, 359, 346, 364.
- 119. Nirmala, 361, 367, 373, 382.
- 120. Rakesh, 365, 373.
- 121. Meena, 366, 367.
- 122. Anup, 368, 373, 379.
- 123. Lallu, 369, 372, 379.
- 124. Somnath, 373, 379.
- 125. Ranjan, 375, 382.
- 126. Sushil, 376, 379.

8. Adolescent Psychosis.

- 127. Godawari, 391, 403.
- 128. Abdul Salam, 391, 393.
- 129. Shanti, 399, 406, 412, 418, 420, 422, 426.
- 130. Thomas, 404, 411, 418, 420, 426.

- | | |
|--|-----------------------|
| 131. Rajkumari, 406, 412, 418, 419, 420, 433. | 142. Kishan, 450. |
| 132. Lalli, 407, 412, 420, 422, 427. | 143. Gur Bachan, 451. |
| 133. Krishna Kumari, 409, 412, 418, 420, 422
426. | 144. Hussain, 452. |
| 134. Onkarnath, 412, 420, 422, 426, 433. | 145. Amarnath, 452. |
| 135. Ali, 420, 422, 426, 433. | 146. Premnath, 454. |
| 136. Promod Kumari, 423, 426. | 147. Dinesh, 455. |
| 137. Indrawati, 427. | 148. Narain, 456. |
| 138. Lado, 418, 419, 433. | 149. Vinod, 457. |
| 139. Somawati, 430, 419, 433. | 150. Mushtaq, 458. |
| | 151. Ikram, 460. |
| 9. Juvenile Delinquency | 152. Mahesh, 461. |
| 140. Arjun, 448, 454. | 153. Ramesh, 464. |
| 141. Kunti, 449. | 154. Rajrani, 465. |

INDEX OF REFERENCE

- (1) HOCH, E.M. "The Problem Child and Community Services". Paper read at Seminar for Child Welfare, Zila Bal Sewa Samiti, Agra, Feb., 1960.
- (2) TRAMER, M. "Zur Entwicklung der Kinderpsychiatrie." *Acta Paedopsychiatrics*, Vol. 27, No. 7, 1960, p. 238-251.
- (3) KANNER, L. "Child Psychiatry ; Retrospect and Prospect". *American Journal of Psychiatry*, Vol. 117, No. 1, July 1960.
- (4) HOCH, E.M. "Commentary on Special Issue on Schizophrenia", Review and Newsletter ; Transcultural Research in Mental Health Problems. McGill University, Montreal, Canada, No. 11, 1961.
- (5) BHATIA, B.D. "Annual Reports of the Child Guidance Clinic of the College of Nursing, New Delhi, 1955-56—1960-61".
- (6) BASSA, D.M. "An Analysis of Cases Attending Child Psychotherapy Centers" *Indian Journal of Psychiatry*, Vol. 4, No. 3, 1962, p. 139-144.
- (7) U.P. CHILDREN ACT Chapt. 1, 2, (4). 1951
- (8) BOSCH, G. "Der fruehkindliche Autismus." Monographien aus dem Gesamtgebiete der Neurologie und Psychiatrie. Heft 96 ; Springer, Berlin, 1962.
- (9) CENSUS OF INDIA Final Population Totals. Paper 1 of 1962. Govt. of India Press, 1962.
- (10) HOCH, E.M. "Contents of Depressive Ideas in Indian Patients". *Indian Journal of Psychiatry*. Vol. 3, No. 1/2, pp. 28-36, 120-129. 1961
- (11) HOCH, E.M. "Indische Christen vom Psychiater gesehen." *Evangel. Missions-magazin*, Vol. 1959, No. 3-4.
- (12) CHANDRA, M.R. and PRASAD, B.G. "Our Children and their Health." *The Pioneer*, Lucknow, Jan. 1st 1961.
- (13) SOUVENIR VOLUME XVTH Annual Conference of Indian Psychiatric Society, March 1962, p. 15.
- (14) SOLOMON, M.A. and HOCH, E.M. "Parental Attitudes". Paper read at Seminar for Child Welfare, Zila Bal Sewa Samiti, Agra, March 1959.
- (15) HEIDEGGER MARTIN "Sein und Zeit." 8th Edition, Tuebingen 1957, p. 122 and 199.
- (16) HOCH, E.M. "Some problems of Child Psychiatry". Paper read at Seminar for Child Welfare, Zila Bal Sewa Samiti, Agra, March 1959.
- (17) HOCH, E.M. "Mental Deficiency or what else ?" Paper read to Indian Paediatric Society, U.P. State Branch, Lucknow, April 1959.
- (18) HOCH, E.M. "Delinquent Features in Children examined at a Private Psychiatric Center." *Journal of Correctional Work*, Govt. Jail Training School, Lucknow, Vol. 1962.
- (19) EXCERPTA MEDICA Section VIII, Neurology and Psychiatry. Volumes 1958-1962.
- (20) TAGORE RABINDRANATH "Reminiscences", quoted from the abridged version : "My Early Life." Macmillan & Co. 1958.
- (21) BOSS, M. "Daseinsanalytische Bemerkungen zu Freuds Vorstellung des "Unbewussten." *Zeitschrift fuer psychosomatische Medizin*. Vol 7, No. 2, p. 130-141. Goettingen 1961.
- (22) BOSS, M. "Psychoanalysis and Dasein's analysis" Basic Books Inc., New York, 1963.
- (23) BOSS, M. "Lebensangst, Schuldgefuehle und psychotherapeutische Befreiung." Hans Huber, Bern 1962.

- (24) HOCH, E.M. "Juvenile Rebels." Paper read at Seminar for Child Welfare, Zila Bal Sewa Samiti, Agra, Feb. 1960.
- (25) SZONDI, L. "Triebpathologie." Hans Huber, Bern 1952/56, and other works.
- (26) MC DONELL, A.A. "A Practical Sanskrit Dictionary" Oxford University Press, 1958.
- (27) SRIMAD BHAGAVAD GITA Various editions, e.g. Sri Ramakrishna Math, Mylapore, Madras, 1948.
- (28) HUXLEY ALDOUS "The Doors of Perception". Chatto and Windus, London, 1954.
- (29) BASSA, D.M. "A case of early infantile autism." *Indian Journal of Psychiatry*, Vol. 4, No. 2, April 1962, quoting: KANNER, L.: *American Journal of Orthopsychiatry*, Vol. 19, p. 416-476.
- (30) FISH, B. *A.M.A. Arch. Neurol.*, Vol. 12, No. 2, 1960.
- (31) VAN KREVELEN, A. *Rev. Psiquiat. Psicol. Med. Europe y Amer. Lat.*, Barcelona 1955, Vol. 2, No. 4, p. 318-325.
- (32) BATLIWALA, B.M. "A case study of a child showing schizophrenic behaviour." *Indian Journal of Psychiatry*, Vol. 1, No. 5, Oct. 1959, p. 251.
- (33) BENEDETTI, G., BLEULER, M., KIND, H., and MIELKE, F. "Entwicklung der Schizophrenielehre seit 1941." Benno Schwabe, Basel, 1960.
- (34) BENEDETTI, G., KIND, H., and JOHANSSON, A.S. "Forschungen zur Schizophrenielehre 1956-1961." *Fortschritte der Neurologie und Psychiatric*, Vol. 30, No. 7/8, p. 341-505. Georg Thieme, Stuttgart, 1962.
- (35) HOCH, E.M. "A pattern of neurosis in India". *American Journal of Psychoanalysis*, Vol. XX, No. 1, 1960.
- (36) BLEULER EUGEN "Lehrbunch der Psychiatrie." 7 Aufl., Springer, Berlin, 1943.
- (37) GLUECK, S. and E. "Unravelling Juvenile Delinquency".

GLOSSARY OF HINDI TERMS

“a—ā”, “i—ī”

First letters of the Hindi alphabet, with which a child starts his writing and spelling.

alu

potato

anna

(1) food

(2) old unit of coinage, corresponding to 1/16 of a rupee. “12 annas in a rupee” therefore means 75%.

areh

exclamation, similar to “o” or “hullo”

āshrama

hermitage, monastery ; in the present context : one of the 4 phases, into which old Indian tradition divided up life, in particular of Brahmins : 1. celibate student, 2. householder, 3. anchorite, withdrawing more and more from worldly life, 4. recluse, having given up all worldly concerns.

āyatana

house, abode, resting place

Baba

popular designation for a “saint” particularly an elderly one

badmāsh

man of bad character, scoundrel.

Baniya

merchant, shop-keeper ; sub-division of the Vaish caste (Hindu)

behosh

unconscious, senseless

Bhagwān

God, the Supreme Being

bhūtapāl

protector of all creatures (Sanskrit Upanishadic term)

bol dena

to speak ; the construction actually indicates “to give speaking”

brahmacharya

celibacy, chastity ; way of life, in which the religious command for chastity is followed

Brahmin or Brahmana

Hindu caste, to which formerly the functions of priest and scholar were reserved

buddhu

stupid, foolish, “idiotic” person

burqa	Muslim item of female dress : a kind of hood which covers the whole figure including the face
chāt	tasty tit-bit, often sold by street vendors
chaprasi	peon, orderly
chapatti or chupatti	flat cake of bread
chipkali	kind of lizard living inside the house, supposed to be poisonous
chhuāchūt	Hindu word meaning untouchability and the taboos concerning it
dacait or dacoit	robber, highwayman
dāī	midwife
Devi	Goddess
dharma	laws of righteous conduct dictated by Hindu religion
Dīwalī	Hindu festival of light, marking the beginning of a new year, celebrated in October or November
Dussehra, Dashahra	Hindu festival, 10th day of special worship of Mother Goddess Durga, celebrated in autumn
fakir	beggar, wandering saint
ghat	easily accessible place on river bank, often for bathing ; burning-ghat : place near a river, where the Hindus burn dead bodies.
hakeem	Muslim indigenous physician
ham	we
Hanumān	Hindu deity, general of the monkey army which helped to rescue Sita from Lanka (Ramayana)
Holi	Hindu festival, celebrated in February or March, somewhat similar to "carneval"
imtehān dena	to "give" an exam ; to do a test
kachha	raw, unbaked ; made of unbaked earth
Kaisth or Kayasth	Hindu caste, by some said to be sub-division of the Vaish, originally mostly clerks and officials in administrative and judiciary service
kaleja	liver ; also used to indicate courage, initiative, "guts"

kal-yug	4th of the "ages" (yug) through which, according to traditional Hindu belief the world has to pass and in which we find ourselves at present ; a period in which all moral standards deteriorate
karma	Hindu theory that one's actions take an effect on one's life, not only in the present existence, but also beyond it in future lives
kurta	tunic, worn by women over wide, baggy trousers in so-called "Punjabi dress"
Kshatriya	Hindu caste of warriors
lagāna	to put on, affect; used in many combinations ; "kuchh lag jaega" : something will stick, remain attached
mae	
maika	maternal (or parental) home of an Indian woman
mantra	magic formula from the Holy scriptures
māya	illusion, deception ; concept of Indian philosophy denoting the illusory nature of concrete phenomena
maulvi	Muslim priest
Memsahab	way of addressing a foreign married lady
mohalla	street, lane
namaste	customary Hindu formula of greeting, saluting
namāz	Muslim prayer ceremony
pāgal	mad, insane
paidaishi	an infirmity existing since birth.
purdah	literally "curtain" ; used to designate the seclusion in which girls and women have to live after physical maturity is reached, particularly amongst Muslims
Rāma	mythological figure, hero of the Hindu epic Ramayana, worshipped as an incarnation of Vishnu
Ramadan or Ramazan	Muslim fasting month, more or less at the time of Christian "lent"
"rickshaw-wallah"	puller of a rickshaw (a small vehicle, mostly nowadays attached to a cycle, for conveying one or two persons).
sanskār	sum of qualities, potentials etc. which a person brings with him at birth as a result of his previous existences

saree	main item of female dress in Hindus, consisting of 5-6 yards of material, fixed round the lower part of the body and loosely draped over a blouse
shalwār or salwār	item of female dress : wide, baggy trousers worn with a "kurta" (see under kurta)
shikār	hunting expedition
Shūdra	the 4th or lowest of the Hindu castes, containing mainly labourers, artisans, certain classes of farmers. Nowadays at times called "scheduled castes"
Sri Krishna	Hindu deity, incarnation of Vishnu
Sīta	mythological figure, wife of Rāma, daughter of Janaka
tahsildār	Government officer, revenue collector, for an area called a "tahsil"
takht	Wooden platform used for sitting or lying, usually covered with some padding and cushions
tika	sign applied to the forehead of women of the upper castes, either with coloured powder or in form of a small metal disc
vijugupsa	Sanskrit term used in some of the Upanishads meaning fear, anxiety, being on one's guard
Yamraj	God of Death
zamindār	landowner, landlord
zenana	women's quarters in a Muslim house



